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# NORTH CAROLINA

## *Medical Journal*

The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY □ □ □ July 1978, Vol. 39, No. 7

### IN THIS ISSUE:

**Community Mental Health Centers: A Continuing Controversy:** Elliott B. Hammett, M.D., Jesse O. Cavenar, Jr., M.D., John L. Sullivan, M.D., and Allan A. Maltbie, M.D.

**Reflux Bile Gastritis Not Related to Previous Gastric Surgery: A Case Report:** Seymour S. Rogers, M.D., F.A.C.S., Roy M. Arkin, M.D., and Howard S. Wainer, M.D., F.A.C.P.

**Primary Carcinoma of the Rectum in a 13-Year-Old Patient:** James Michael Kelsh, M.D., and F. Walton Avery, M.D.

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Sept. 27-Oct. 1—Southern Pines

1979 Leadership Conference  
February 2-3

1979 Annual Sessions  
May 3-6—Pinehurst



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**Often a significant feature**  
**of irritable bowel syndrome\***

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\*Librax has been evaluated as possibly effective for this indication.  
Please see brief summary of prescribing information on following page.

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**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

“Possibly” effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or cildinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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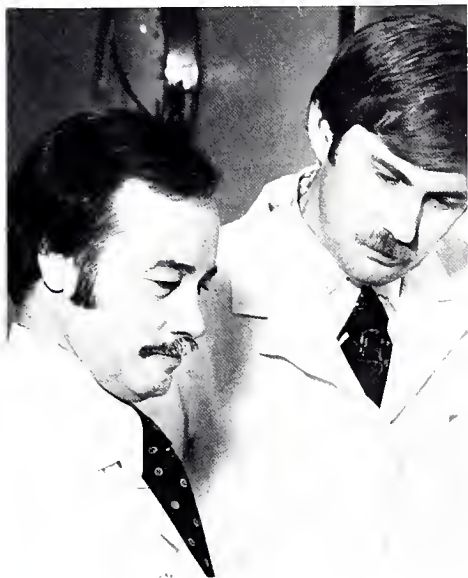
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# NORTH CAROLINA MEDICAL JOURNAL

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July 1978, Vol. 39, No. 7

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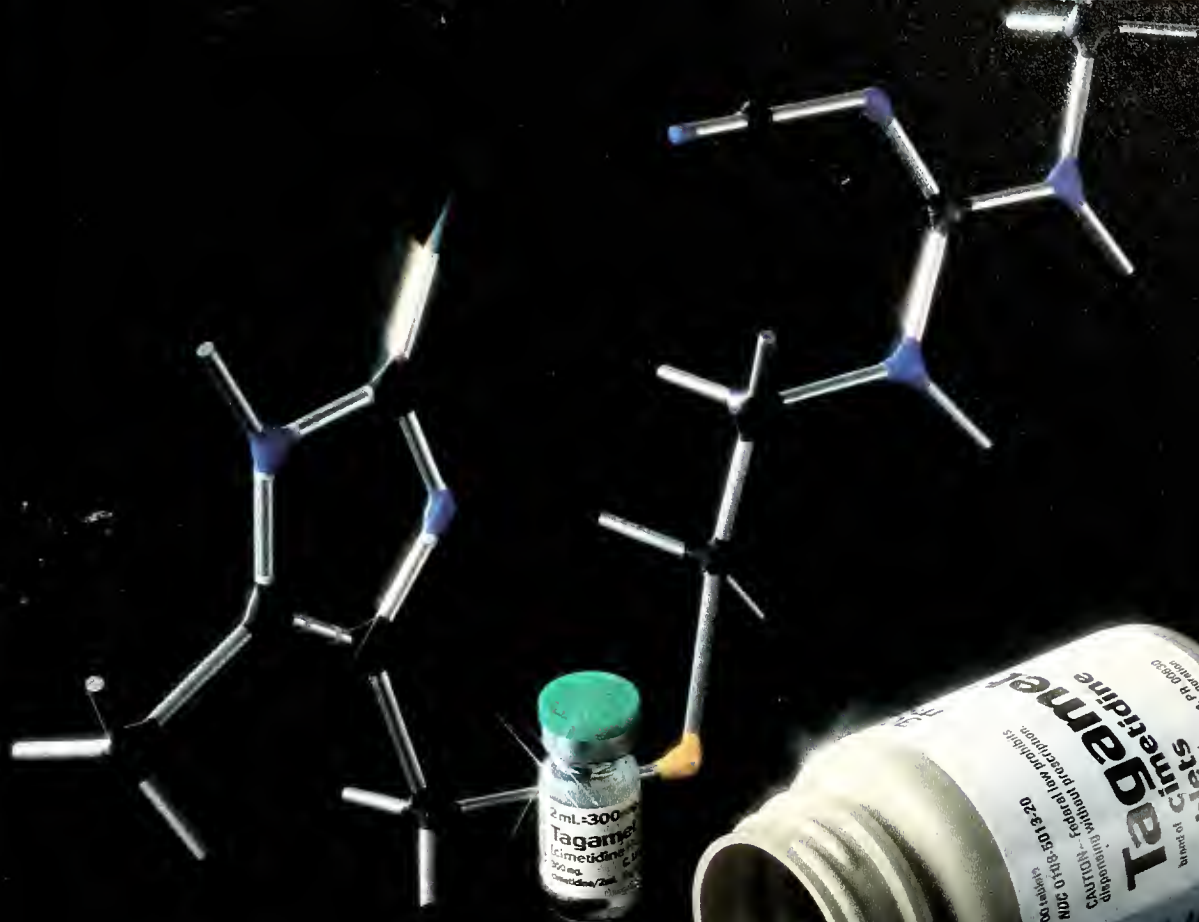
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Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for  
the pain

for  
the pathogens

\*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete product information, a summary of which follows. **Indications:** In adults, urinary tract infections complicated by pain (primarily pyelonephritis, cystitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. Note: Fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. amidebenzoic acid to follow-up culture media. increasing frequency of resistant organisms. the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels; variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Children below age 12; sulfonamide hypersensitivity; pregnancy at term; during nursing; pericarditis; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatic uremia, and pyelonephritis of pregnancy with disturbances.

**Warnings:** Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs of throat, fever, pallor, purpura or jaundice may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergic bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria or stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypochromia and methemoglobinemia); skin reactions (erythema multiforme, skin eruption, Stevens-Johnson syndrome, epidermal necrolysis, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, desensitization, arthralgia and allergic myalgia); G.I. reactions (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis, colitis, stomatitis); CNS reactions (headache, vertigo, neuritis, mental depression, convulsions, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, nephrosis with oliguria and anuria, pericarditis, myxema and L. E. phenomenon). Due to chemical similarities with some antidiuretics (acetazolamide, thiazides) and cardiovascular agents, sulfonamides have caused instances of goiter production, diuresis and glycemia. Cross-sensitivity with these agents may exist.

**Dosage:** Azo Gantanol is intended for the painful phase of urinary tract infections. Use adult dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists after relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

**NOTE:** Patients should be told that the red dye (phenazopyridine HCl) will color the urine.

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#### BRIEF SUMMARY

**Indications:** Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

**Contraindications:** Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

**Precautions:** Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

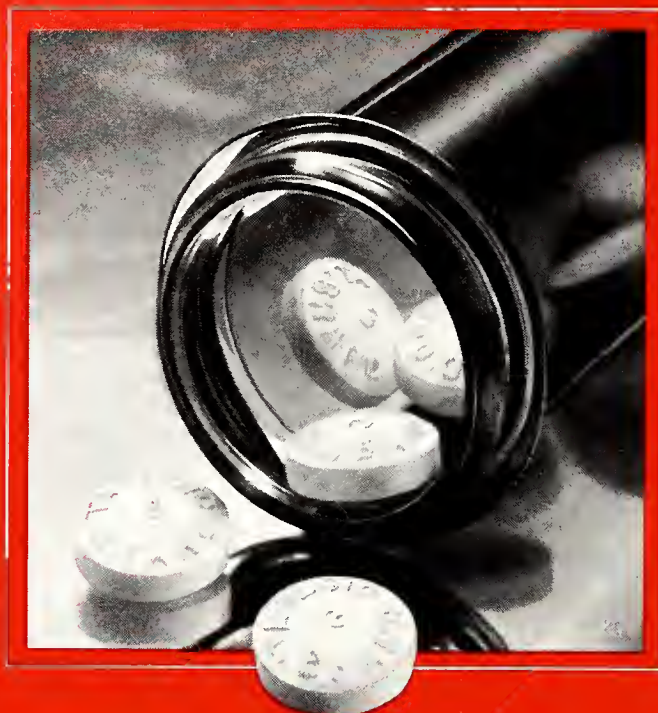
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

**Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

**Overdosage:** Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

**Kaon<sup>®</sup> Elixir**  
(potassium gluconate)  
20 mEq per 15 ml

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Halcinonide Cream 0.1%



Discoid lupus erythematosus

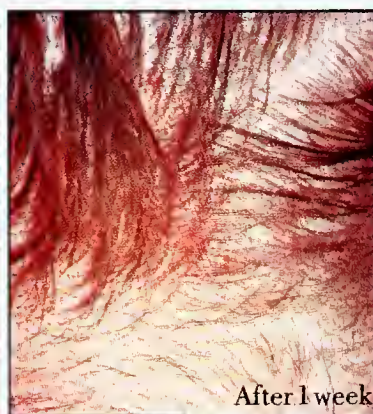


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Halog Cream 0.025% (Halcinonide Cream 0.025%) and Halog Cream 0.1% (Halcinonide Cream 0.1%) contain 0.25 mg and 1 mg halcinonide per gram, respectively, in a specially formulated cream base. Halog Ointment 0.1% (Halcinonide Ointment 0.1%) contains 1 mg halcinonide (0.1%) per gram in Plastibase<sup>®</sup> (Plasticized Hydrocarbon Gel), a polyethylene and mineral oil gel base. Halog Solution 0.1% (Halcinonide Solution 0.1%) contains 1 mg halcinonide (0.1%) per ml.

**CONTRAINDICATION:** Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

### PRECAUTIONS:

**General**—If irritation develops, dis-

continue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.

**Usage in Pregnancy**—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been

associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients in large amounts, or for prolonged periods of time.

**Occlusive Dressing Technique**—The use of occlusive dressing increases the percutaneous absorption of corticosteroids. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. Keep the patient under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Discontinue use of the occlusive dressing if there is elevation of body temperature.

Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

**ADVERSE REACTIONS:** The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning sensation, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

For full prescribing information, consult package inserts.

**HOW SUPPLIED:** The 0.025% and 0.1% Cream and the 0.1% Ointment are supplied in tubes of 15 g and 60 g, and in jars of 240 g (8 oz). The 0.1% Solution is supplied in plastic squeeze bottles of 20 ml and 60 ml.

## Hallog Ointment 0.1% Halcinonide Ointment 0.1%



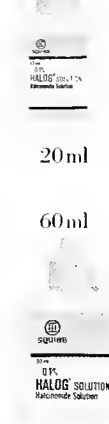
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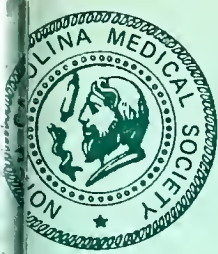
## Hallog Cream 0.025% Halcinonide Cream 0.025%



## Hallog Solution 0.1% Halcinonide Solution 0.1%







# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

o. 2

July 1978

Our Medical Society was well represented by its Delegates, Alternate Delegates, Officers, and Staff at the AMA Convention in St. Louis, Missouri, June 17-22, 1978. There were 260 resolutions and Trustee Reports to be considered by the Reference Committees and acted on by the House of Delegates. Each of the 48 items in the report of the National Commission on the Cost of Medical Care was discussed in the Reference Committees and by the House.

In addition to the five North Carolina Delegates, this year, for the first time, we had four additional delegates from the Specialty Sections. They were Dr. Thomas Dameron, Raleigh, Section on Orthopaedic Surgery; Dr. Nicholas Georgiade, Durham, Section on Plastic Surgery; Dr. Kenneth Brinkhous, Chapel Hill, Section on Pathology; and Dr. William Hudson, Durham Section on ENT. This gave North Carolina nine voting members in the House of Delegates.

Congratulations to Dr. Eben Alexander, Neurosurgeon from Winston-Salem, who was elected to membership on the AMA's Council on Medical Education. This Council is primarily involved in the accreditation and evaluation of medical education programs at all levels from graduate to post-graduate continuing medical education. Dr. Alexander, a native of Knoxville, Tennessee, graduated from the University of North Carolina and Harvard Medical School. Since 1949 he has served as Chief of Neurosurgery at the N. C. Baptist Hospital and became Professor of Neurosurgery in 1954. The N. C. Medical Society is proud to have two of our distinguished physicians serving on AMA Councils: one on the Council on Medical Education and Dr. John Glasson, Durham, is a member of the AMA Council on Medical Service.

There is a new bill proposed by Senator Kennedy and Representative Rogers which will have far reaching effects in the pharmaceutical industry. Senate Bill 2755 entitled "DRUG REGULATORY REFORM ACT" proposed several changes including a company developing a new drug will have only five years to use it then new drugs will be licensed to all companies; a book will be published including generic names for all drugs, and patient inserts will be required for all drugs. According to a spokesman from the pharmaceutical industry, enactment of this bill would lead to pharmaceutical companies doing most of their research work abroad.

We received an interesting piece of information from the AMA. This was a comparison of the level of dues for the State Medical Societies in various states. Even with our recent increase in dues, we are still 39th in rank order among the various states. The average dues in 1978 was \$190 with the spread from \$100 to \$310. In addition to this, a number of states had assessments ranging from \$5 to \$60 for special purposes. I am sure that this information does not assuage the distress of those who feel that all Society dues are too high, but perhaps it will help to know that others pay much more.

Efforts are underway to extend and amend the National Health Planning Act. A grant program to assist and encourage discontinuance of unneeded hospital services through voluntary closure and conversion is included in the Administration

sponsored Senate Bill 2551. Highlights include: (1) replacing the current funding formula by HEW Discretionary Grants, (2) broadening the scope of state certificate-of-need programs to require coverage of major medical equipment whether it is located in a medical institution or elsewhere, (3) changing the compositional requirements of HSA Governing Boards to require that at least 25 percent of the members be public elected officials or representatives of government authorities, (4) returning any full designated HSA to conditional status for up to 24 months if it is not fully performing all mandated functions and requirements, (5) allowing the Secretary of HEW to split an interstate area into multiple service areas on the request of a single Governor.

We have planned a "Think Tank Conference" of the Medical Society Officers, Medical Auxiliary Officers, Councilors, Vice-Councilors, and Past-Presidents in Williamsburg, Virginia, July 27-30, 1978. At this time we will be discussing the internal structure of the Medical Society. We will pay particular attention to Commissions and Committees, relation of the State Society to District and County Medical Societies, increasing membership, format for our Annual Meeting in Pinehurst, and long range planning and goals for our Medical Society. I believe this will be a fruitful session and hope we can develop new ideas and programs for the Committees to discuss at the Committee Conclave in Mid Pines, September 27-30, 1978.

There has been some discussion recently of the word "fraud" and "abuse" which are often used interchangeably in reporting problems with persons and agencies providing service to Medicare and Medicaid patients. Frank Campion of AMA gives an excellent distinction. "The term 'fraud' is defined, for purposes of imposing penalties under the Social Security Act, as the making (or causing to be made) of 'any false statement or representation' of a material fact 'willfully, knowingly, and with intent to deceive'. As such, it is subject to conviction of a misdemeanor and fines. The term 'abuse' may include fraud, but is not necessarily fraud. The term 'abuse' is defined as 'a corrupt practice or custom, improper use or treatment, or misuse'. The term 'abuse' is commonly used to refer to overutilization of medical and health services or the provision of services not considered medically necessary. The criminal intent of 'fraud' may be absent in such cases. Less confusion in the public's mind might occur if the terms were not used interchangeably."

Two additional AMA Medical Staff Leadership Seminars are scheduled for later this year--one September 29-30, 1978, in New Orleans at the Fairmont Hotel and the other on November 3-4, 1978, in Miami Beach at the Eden Roc Hotel. Each seminar, approved for 14 hours Category I CME credit, will consider JCAH Standards...Medical Staff Bylaws...Responsibilities of the Medical Staff and the Hospital Governing Boards...and Responsibilities and Duties of the Hospital Chief of Staff...among a wide range of other topics. For more info contact: AMA Dept. of Hospitals and Health Facilities.

We wish for each of you a serene, peaceful, refreshing vacation by calm, blue, rippling waters to refurbish your mind and soul for continued dedication and devotion to the welfare of our patients.

Sincerely,



D. E. Ward, Jr., M.D.  
President



# An uncommon place

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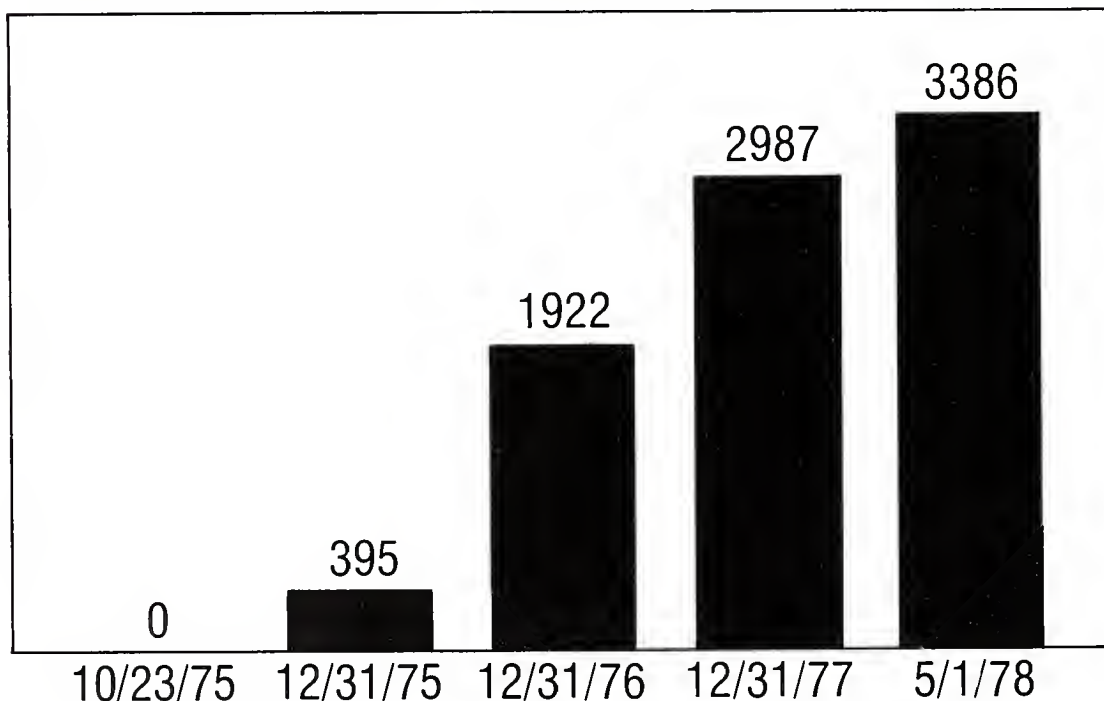
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# Community Mental Health Centers: A Continuing Controversy

Elliott B. Hammett, M.D., Jesse O. Cavenar, Jr., M.D.,  
John L. Sullivan, M.D., and Allan A. Maltbie, M.D.

**ABSTRACT** The history of the community mental health center (CMHC) movement is described and both local and nationwide criticism of the centers as well as the National Institute of Mental Health response are presented. The authors suggest that an operational definition of a CMHC, specifically whether it is a medical practice, must be clarified. Inconsistencies between the philosophy and the actual operations are noted, and suggestions to improve patient care, community and medical acceptance and personnel recruitment problems are given.

**C**OMMUNITY mental health centers (CMHCs) have been controversial since their beginning in 1963. Recently, both concerned laymen and medical practitioners have again raised questions about the intent, practices and usefulness of the centers.

A recent study by the N.C. Mental Health Association stated that

people without medical training were dispensing drugs to CMHC patients at their own discretion and it was suggested that psychiatrists at times signed prescriptions and left drugs to be distributed to patients if the non-medical staff felt the drugs were indicated. The same study was critical of some CMHCs for allowing social workers or nurses to assume total responsibility for patients without medical or psychiatric guidance. In surveying 43 centers, the association found that the quality of care ranged from very good to inferior.

One North Carolina county medical society, stating that the diagnosis and treatment of illness constitutes the practice of medicine, passed a resolution urging appropriate state authorities to take action to stop such activity in CMHCs by non-physicians.

The criticism of CMHCs is not confined to North Carolina; it is an issue throughout the United States. The following review of the philosophy, ideas and laws governing the centers is undertaken to help focus the criticism.

## HISTORY

The National Mental Health Act of July, 1946, created the National Institute of Mental Health (NIMH). R. H. Felix, the first director, en-

visioned mental illness as a public health problem and proposed to use methods which had been most successful in dealing with health problems in other fields.<sup>1</sup> He later believed that ideal locations for treatment would be properly-staffed outpatient clinics with one for every 100,000 citizens throughout the country. In this way mental illness would be dealt with and eradicated much as pulmonary tuberculosis had been.<sup>2</sup>

By 1961, the NIMH had prepared plans for CMHCs and proposed to have 2,000 such centers in operation by 1980. President Kennedy, in an address to Congress in 1963,<sup>3</sup> stated that "a concerted national attack on mental disorders is now both possible and practical." The attack was to be orchestrated through the CMHCs where it would be "possible for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society."

The CMHC bill, signed by President Kennedy in October, 1963, provided for three years of construction to cost \$150 million between 1964 and 1967. In 1965, President Johnson signed legislation providing \$73.5 million for staffing, and the CMHCs came into being.

From the preliminary report from

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the President's Commission on Mental Health in September, 1977, it appears that CMHCs will be the major avenue of delivery of mental health care in the future. Brown,<sup>4</sup> the most recent director of NIMH, has stated that in the coming years the federal government will make an all-out effort to strengthen the system. He notes 93 new CMHCs will be funded each year between 1979 and 1983, at which time 1,100 CMHCs should be in operation. Total national coverage by a network of CMHCs is envisioned by the end of 1988. Given the intent of NIMH to make the CMHC system the model of delivery of mental health care, it seems appropriate to examine the criticisms of the centers.

### CRITICISMS

Many have criticized the CMHC theoretical framework and even more have been critical of the actual performance and productivity of the centers. Robitscher<sup>5</sup> recently charged that CMHCs provide a "diluted and de-professionalized" approach to psychiatric care and that the centers are "a political promise of help, but much of the help is sham." He said CMHCs use few psychiatrists who have minimal contact with patients but ultimate responsibility, and that the centers use many para- and semi-professionals who act as therapists. He further suggested that therapists with inadequate backgrounds try to help patients although they may not understand what "help" really is or how to deliver it. He noted that many of the therapists soon "burn out" and drop out of the system — or seek treatment themselves with a therapist who does not work in the CMHC system. He finds it paradoxical that the therapists may "purchase for themselves an entirely different kind of mental health treatment than they give to their clients" in the CMHC system. Robitscher concluded by noting that some critics believe that many of the patients of the CMHC would be better served by giving them the money that the service cost instead of the service.

The cost of services is indeed

considerable. The NIMH has reported<sup>6</sup> that for 1976, the total cost of the CMHC program in the United States was \$800 million, the average cost per patient was \$400 and the cost per-treatment-hour was \$45, compared to \$37 cost per-treatment-hour in a private psychiatric practice. The difference in cost is magnified when it is realized that there were some 2 million patient visits to CMHCs that year.

An American Psychiatric Association task force has attempted to study the performance of CMHCs. Its report<sup>7</sup> noted that "while it has been the policy of NIMH to give high priority to research support, it must be acknowledged that in the area of community mental health this policy has not been implemented with the attention required by the newness of the programs and their scope." The task force got a strong subjective impression that NIMH was strongly resisting evaluation of the performance of the CMHCs.

The 1974 Nader report<sup>8</sup> on NIMH, entitled *The Medical Establishment*, asserted that "CMHCs have been neither accountable backward to the NIMH, which established them, nor forward to the consumers and citizens in the community they allegedly serve."

Winslow<sup>9</sup> has observed that over the past five years, psychiatrists have gradually but steadily been deserting CMHCs and that psychiatrists who become involved in community mental health find other mental health workers hostile and competitive; at some CMHCs, the psychiatrist is given duties consisting primarily of signing prescriptions. He adds that originally a CMHC was required to have a psychiatrist as the director, but now, under changed regulations, any "mental health professional" can be the director and that, in fact, some centers feel that a psychiatrist is not needed at all. Such trends leave the CMHC movement in "great jeopardy" and foretell a deficient mental health system developing in CMHCs. He predicts that society may well reject the CMHC movement as inferior.

Goldman<sup>9</sup> believes that older psychiatrists avoid CMHCs because they are not "captains of the team" and younger psychiatrists because of uncertain funding. Beck<sup>1</sup> blames the Department of Health Education and Welfare for the shortage of psychiatrists in CMHCs because HEW has failed to stress the role of psychiatrists as essential. He further states that many psychologists and social workers feel threatened by psychiatrists and therefore do not work well with them.

The executive director of the National Council of CMHCs admits that the shortage of psychiatrists in the centers is real, and reports that the council is establishing a panel of experts to seek solutions to the problem. Langsley<sup>10</sup> noted that recently in one state mental health department only one of 110 positions was filled by a psychiatrist because the administration said it could "buy three social workers for one psychiatrist."

NIMH has measured the success of CMHCs by showing that the average census in state mental hospitals dropped from 557,000 in 1957 to 193,000 in 1975. Critics say, however, that CMHCs cannot claim credit for this decline, that, in fact, there has been an increase in the number of admissions to state mental hospitals during this same time period, from 200,000 in 1956 to 375,000 in 1975. Thus, they say CMHCs are not providing preventive care in the community. The decrease in the number of patients hospitalized appears rather to be the result of improved psychopharmacology and other therapeutic methods and of the questionable and debatable practice of discharging large numbers of chronic patients to community care, nursing homes and their families. Many critics question whether this practice is actually more humane.

It seems clear that criticisms of CMHCs will continue until adequate scientific studies delineate what the centers are doing and how effectively and economically they are operating.

Collectively we have had 14 years of experience as consultants to



CMHCs in various locations and in a position to offer some observations which might prove helpful.

## RECOMMENDATIONS

The chief criticism of CMHCs from the medical profession as a whole is that adequate psychiatric coverage is in many cases simply not available. The medical community wants, and believes it should have, facilities where patients who present emotional and psychiatric problems can be referred for adequate evaluation and treatment. Unfortunately, many CMHCs do not offer this range of services. This situation leads to distrust, antagonism and hostility between the CMHC and the community's physicians.

The basic problem appears to be an inadequate definition of exactly what a CMHC should be and do. Brown,<sup>5</sup> while director of NIMH, stated that a CMHC is not a vehicle for the delivery of psychiatric care; he suggests that this notion is a basic misconception held by the medical community. He notes that the CMHCs were "designed with the intent of providing a range of accessible, quality mental health services to the broadest population in need. Multidisciplinarity was a basic strategy in providing the necessary scope of services." We find this statement vague and basically unrealistic as an operating statement.

The fact is that every patient seen at a CMHC in this state has a responsible physician designated either by name or code number on a standard form in the patient record. That physician may never actually see the patient; the counseling or psychotherapy may be provided by a psychologist, social worker, or other mental health professional. This medical records requirement makes it appear that the authorities envision the CMHC as a vehicle for the delivery of medical and/or psychiatric care. If not, it would seem unnecessary that the patient have, on paper, a responsible physician. The possible medicolegal liability of being listed as the patient's responsible physician when in fact one may never see the patient

is not a situation in which most physicians want to find themselves. This practice is one reason that many physicians, psychiatrists in particular, are hesitant to consult with, or be employed by, CMHC. The internal inconsistency between the stated NIMH philosophy and the reality appears to be great. We believe that this internal inconsistency must be clarified on an operational level. If the CMHC is in fact a multidisciplinary practice approach, physicians should be responsible only for those patients whom they are treating, and other professionals responsible for their patients. If the working definition of a CMHC were clear, the general public and medical community could be so informed. Physicians would then know whether their patients referred to a CMHC would or would not be seen by a psychiatrist. The community physician would then be in a much better position to decide whether he wanted to refer his patient to a private psychiatrist or to the CMHC.

On the other hand, if the decision were made that a CMHC does constitute the practice of medicine and each patient needed a responsible physician, there are several things that might be done to make centers more attractive to the physician for either part-time or fulltime employment.

First, most CMHCs are under the direction and management of a non-physician. While it is true that many hospitals are administrated by non-physicians, the situation in CMHCs is not analogous. Most hospitals are required to have organized medical staffs; many CMHCs do not. In CMHCs where part-time psychiatric consultants are used, the physicians may never meet as a group. If one physician is employed fulltime, he or she alone may constitute the medical staff. Given these situations, some non-physician administrators may at times, without medical advice and guidance, make administrative operational policy that borders on medical operational policy, and this is a most uncomfortable position for the physicians involved. We believe that the format which has been used

in the Veterans Administration for years would be a workable option; a physician is head of a particular service and a non-medical administrative assistant handles the day-to-day non-medical operation of the service. The administrative assistant is directly responsible to the physician. If CMHCs could be organized in a similar manner, more physicians might be interested in pursuing careers with the system.

One difficulty the medical directors of North Carolina mental hospitals have noted in recent months is that they have little, if any, voice in hiring those who are to care for patients. Although they are charged with the ultimate responsibility for patient care, they have no influence on personnel procedures. This same situation exists in many CMHCs; it could be alleviated by having a physician in charge of the center.

Another approach which would clarify functions in CMHCs would be the encouragement — or requirement — of medical staff meetings. If such were required, as they are at most hospitals, medical opinions could be expressed and presented to the administrative body of the center.

Under North Carolina statutes, CMHCs are governed by an area mental health board of 15 citizens. The philosophy underlying this method is that these citizens should be able to address issues that are peculiar to the community and thereby direct the mental health programs in the best interest of the community. While this seems quite reasonable, there is always the potential for partisan politics to enter into policy decisions. Clearly, when politics becomes involved in directing the range and scope of health services of any type, conditions may worsen. Perhaps the situation needs reevaluation, with more direct guidance from the medical society of the particular region.

The county commissioners control part of the budget of the CMHCs, primarily that portion which must come from local funds. While this is indeed reasonable (a CMHC is a community facility), it nonetheless leaves some programs in a situation where political con-

siderations almost certainly influence the funding of health programs.

While political considerations are a fact of life, and every organization has governing boards or bodies, for a lone physician to become deeply involved at a CMHC is simply not an appealing prospect. Perhaps the governing and financial structures could be altered so that a physician at a CMHC might feel less vulnerable.

Whether or not the medical com-

munity agrees with the concept of CMHCs, it appears that this system has been established by the federal government which sees for it a long life. We believe that discussion by the appropriate bodies of the issues we have addressed here would lead to greater acceptance of the CMHCs by the people, higher productivity and better patient care. We urge medical practitioners to take an active interest in their own CMHCs in an effort to clarify some of the vague philosophy and its con-

sequences for the communities the state.

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Timorous Animals are observed to have larger Hearts than courageous ones; as Deer, Asses, Hares, etc. which holds true in the Instance of this Doe's Heart. May not one Reason of this be, that the Fibres of the timorous are generally more lax than those of courageous Animals, on which Account the Blood passing with less Resistance through the lax fibred capillary Vessels, it was requisite that the Heart should at each Pulse throw out a greater Quantity of Blood, in order to supply its more easy and plentiful Flow through the lax capillary Arteries into the Veins? And may not this be the Reason why the Pulses of young Animals, as of Children, are found to beat faster than those of grown Persons, viz. because the tender Fibres of the Coats of their Blood Vessels being very lax, they give the less Resistance to the flowing Blood; whose Globules are observed by *Leewenboeck* to be all of a Size both in great and small Animals; Whence it was needful to make Provision for a proportionably greater Supply of it from the Heart, by increasing the Velocity of the Dilatations and Contractions of that curious Engine; in the Formation of which are seen such evident Marks of the consummate Wisdom of the great Author of Nature. — *Statical Essays: Containing Haemastaticks* by Stephen Hales, London. 1733.

# Reflux Bile Gastritis Not Related to Previous Gastric Surgery: A Case Report

Seymour S. Rogers, M.D., F.A.C.S., Roy M. Arkin, M.D., and  
Howard S. Wainer, M.D., F.A.C.P.

**ABSTRACT** A patient with an intact pylorus, possibly secondary to cholecystectomy who developed reflux bile gastritis is described. Because she did not tolerate cimetidine well, she underwent surgery for diversion of duodenal contents. Her gastrointestinal symptoms have been relieved and she gained 20 pounds since vagotomy and antrectomy with Roux-en-Y end-to-side gastrojejunostomy were performed. Although reflux bile gastritis usually follows gastric surgery, occasionally it occurs with an intact GI tract (or stomach).

**INTRODUCTION** During the past 20 years a condition called bile reflux gastritis, alkaline reflux gastritis or postoperative reflux gastritis has been recognized. It is characterized by epigastric or upper abdominal pain frequently aggravated by food; hypochlorhydria or achlorhydria; endoscopic and often histologic evidence of superficial gastritis; nausea and vomiting, usually chronic; weight loss; anorexia and at times chronic blood loss with anemia. In most cases the pyloric antrum had been removed, de-

stroyed or bypassed during previous gastric surgery. The occurrence of the condition in a patient without upper gastrointestinal surgery has been rarely and incompletely reported.<sup>1-3</sup>

Scudamore<sup>1</sup> observed such a condition in non-operated as well as postgastrectomy patients and noted that others had suggested that gastritis might be secondary to bile reflux through an incompetent pylorus or a postgastrectomy stoma. Twenty-three of his patients had had no gastric surgery but 18 of them had undergone cholecystectomy and four others had evidence of gallbladder disease.

This report describes this syndrome in a patient whose gastrointestinal tract was unaltered by surgery but who had undergone cholecystectomy for cholelithiasis about two years earlier.

## CASE REPORT

A 39-year-old white woman was hospitalized because of a two-year history of postprandial epigastric pain, nausea and bilious vomiting and a 10-pound weight loss during the preceding six months. The diagnosis of alkaline gastritis with bile reflux had been made gastroscopically and confirmed elsewhere, serial gastric biopsies revealing mucosal and submucosal inflam-

mation. Dietary and anticholinergic therapy and the oral administration of Bethanicol and cholestyramine were begun but the patient's acceptance of and her response to treatment were not satisfactory. However, treatment by nasogastric suction had afforded temporary relief of symptoms on several occasions. She had had a cholecystectomy for cholelithiasis and incidental appendectomy in 1974 and an umbilical herniorrhaphy in 1976. Physical examination was unrevealing and laboratory studies were unremarkable except for a hemoglobin of 11.5 g. Gastric analysis revealed basal hypochlorhydria with minimal MAO (maximal acid output). After nasogastric suction had been started and appropriate fluids and electrolytes administered intravenously, the patient's symptoms abated, and at her request surgery was postponed and she was discharged. About three days after discharge, her symptoms returned and she re-entered the hospital for the recommended surgery. On August 12, 1976, the patient underwent vagotomy and antrectomy with Roux-en-Y end-to-side gastrojejunostomy. After the operation, delayed gastric emptying was resolved after two weeks of gastric drainage and after she left the hospital the patient noted complete re-

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Durham, North Carolina.  
Requests to Dr. Rogers  
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lief of abdominal pain and vomiting. Postoperative gastroscopy was normal. When last seen, 15 months later, she had no gastrointestinal complaints and had gained 20 pounds.

## DISCUSSION

The effect of duodenal contents and other gastrointestinal ferment on the gastric mucosa is the subject of considerable discussion and controversy.<sup>2, 4, 6, 7, 8, 10, 11</sup> Symptomatic reflux gastritis may be related to an abnormality of composition or concentration of bile, pancreatic juice or succus entericus; to sensitivity of the gastric mucosa to a normally constituted duodenal content; or to the duration and frequency of contact between gastric mucosa and duodenal contents.

In a patient who has had the pyloric sphincter mechanism destroyed, excised or bypassed (e.g. after gastrectomy or vagotomy with antrectomy or pyloroplasty) any or all of these factors could be altered.

The frequency and duration of reflux would naturally be increased, and antrectomy or vagotomy or its combination could be responsible for a change in mucosal sensitivity and/or mucosal protective mechanisms.

In patients with surgically unaltered upper gastrointestinal tracts, similar pathophysiological mechanisms may be present, although, symptoms may be less prominent. Duodenal contents are known to be present at times in the stomach of unoperated patients,<sup>2, 8, 10-12</sup> and their role in the development of gastritis and gastric ulcer has been considered.<sup>8-11</sup>

Complete diversion of duodenal contents from the gastric mucosa appears to be a logical solution to this problem. In the patient who has not had gastric surgery, maneuvers to decrease acid secretion are indicated, since hypochlorhydria may be reversed after duodenal diversion.<sup>2-5</sup> As in many conditions where physical and laboratory findings are scant, predisposing

anatomic and physiological factors are found in many asymptomatic individuals and patient selection the paramount problem.

Our patient was first treated medically with cholestyramine,<sup>1, 4</sup> a bile-salt binding resin. Although her symptoms were somewhat improved, she tolerated the drug poorly. Since we believed that the criteria for diagnosis of alkaline reflux gastritis had been met, we then recommended surgery.

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1 Slit open with a Pair of Scissors, from end to end, the Guts of a Dog, on that side which was opposite to the Insertion of the mesenterick Arteries and Veins; and having fixed a Tube 4 + ½ Feet high to the descending *Aorta* a little below the Heart, I poured blood warm Water thro' a Funnel into the Tube, which descended thence into the *Aorta*, with a Force equal to that, with which the Blood is there impelled by the Heart: This Water passed off thro' the Orifices of innumerable small capillary Vessels, which were cut asunder thro' the whole Length of the slit Gut. But notwithstanding it was impelled with a Force equal to that of the arterial Blood in a live Dog, yet it did not spout out in little distinct Streams, but only seemed to ouze out at the very fine Orifices of the Arteries, in the same manner as the Blood does from the capillary Arteries of a Muscle cut transversely. — *Statical Essays: Containing Haemasticks* by Stephen Hales, London, 1733.

# Primary Carcinoma of the Rectum in a 13-Year-Old Patient

James Michael Kelsh, M.D., F.A.C.S., and F. Walton Avery, M.D., F.C.A.P., F.A.S.C.P.

**ABSTRACT** A 13-year-old black male was found to have carcinoma of the rectum which presented with anemia, weight loss and finally right rectal bleeding. While such tumors are rare in children and adolescents, the presence of suggestive symptoms obligates the physician to make a thorough diagnostic survey.

THE incidence of carcinoma of the lower gastrointestinal tract in adolescence is so low that the process is often not suspected until it is far advanced. Consequently the physician may be lulled into a false security when a child is seen because of rectal bleeding. We have recently seen a young patient with such a problem and wish to present our experience.

## CASE HISTORY

A 13-year-old black male was admitted to the Edgecombe General Hospital on November 12, 1976, because of moderate weight loss during the previous six months.

Five months earlier anemia had been discovered and iron prescribed. Weight loss continued, however, and bright red rectal bleeding was first observed the day of hospitalization. There was no history of jaundice or of obstructive symptoms except for occasional bouts of diarrhea during the preceding two weeks. The child had not been operated on and had always been healthy. He was one of nine children in a family with no history of polyposis or of malignancy. Physical examination revealed a thin male appearing small for his age. Blood pressure was 126/80 mm Hg, the pulse rate 108 per minute. Positive findings were limited to the rectal examination which disclosed a rock-hard fungating mass 3.5-4 cm beyond the anus, beyond which the examining finger could not reach. Two biopsies were taken at proctoscopy and disclosed adenocarcinoma, probably primary in the rectum. A liver scan was unremarkable, while a barium enema revealed a marked annular constriction of the rectosigmoid approximately 7-8 cm in length with some obstruction to the retrograde flow of

barium. There was loss of mucosa in the constricted area and a probable small ulceration of the central portion. An intravenous pyelogram was considered normal and no tumor was seen at cystoscopy carried out under general anesthesia, although there was a suggestion of pressure upon the posterior bladder wall. The hemoglobin was 9.7 g. Other laboratory studies were within normal limits as was a chest x-ray. At laparotomy the tumor was found to extend to just below the rectosigmoid junction and was not fixed to any neighboring structure. There was no gross lymphadenopathy within the mesentery or the small or large bowel. An abdominal perineal resection was carried out without difficulty. The patient has done well postoperatively, gaining weight and seeming to adjust well to his colostomy. Following discharge he was started on radiation therapy consisting of 4500 Rads in twenty different fractions to the pelvis and tumor bed. He also received an initial chemotherapeutic regime including 5-Fluorouracil (5-FU), dacarbazine, Vincristine and bis-chloro-nitrosurea. He is currently

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Edgecombe, North Carolina 27886  
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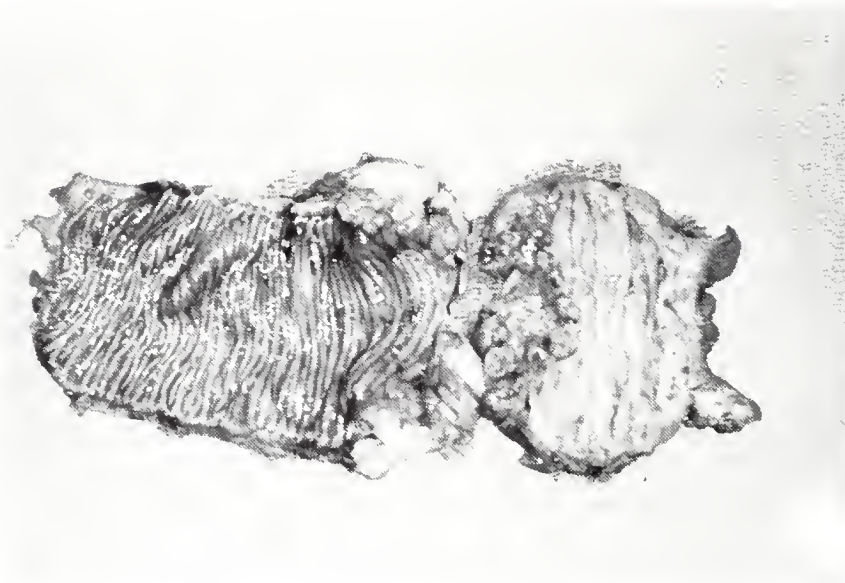


Figure 1. The resected tumor mass.

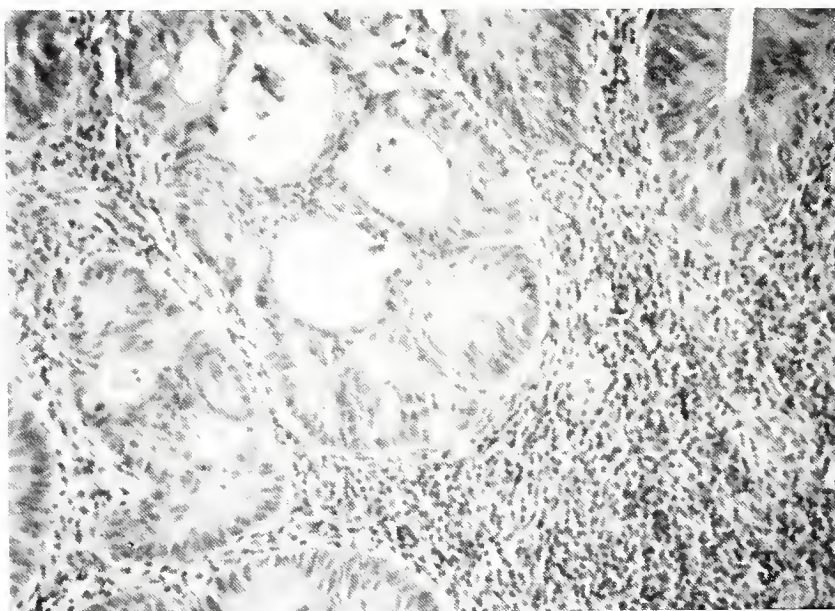


Figure 2. At the tumor's edge there is abrupt transition from normal colonic mucosa to neoplasm.

on 5-FU alone and followup show no evidence of recurrence one year following surgery.

At the edge of the surgical specimen normal colonic mucosa exhibited an abrupt transition to neoplastic epithelium (Figure 1) which formed single and multiple glands, exciting a marked desmoplastic response. In the surrounding fibrous tissue were dense aggregates of lymphocytes and plasma cells (Figure 2). Focal mucin production was noted as well as extension of the tumor into lymphatic perineural spaces. One lymph node contained metastatic adenocarcinoma.

## DISCUSSION

Review of the literature reveals few reports of primary rectal and colon carcinomas in children and young adults. Hall and Coffey<sup>1</sup> report an incidence of 3% of these tumors in individuals under 40 years of age. In 1970 only 97 patients under 18 had been reported with carcinoma of the colon in English language journals. Langenberg<sup>2</sup> suggests that the incidence of colorectal carcinoma in young people is increasing and indicates that such tumors are likely to exhibit more malignant characteristics. It must therefore be obvious that the same diagnostic approach called for in cases of rectal bleeding in adults — namely, digital rectal examination, proctoscopy and barium enema — should be employed when younger patients present with similar symptoms.

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When we view in a strong Light the Blood circulating in the Lungs of a Frog, we see the Arteries as they pass on, sending Branches, which spread like a fine Net-work over the Surface of each Vesicle; and on some of these Vesicles we may very plainly see, the Blood when it has pass'd over little more than half their Surfaces, to enter corresponding capillary Veins, which thence unite in large Trunks; but on the greatest part of the Vessels, the extream capillary Arteries, reach to the Verges of the Vesicles, and there enter at right Angles the Veins, which run along the Limits of those Vesicles; which Veins laying on the inner Sides of those Vesicles they are not visible like the Arteries: But when in here and there a Place I have clearly seen those Veins, I have then also seen the extream capillary Arteries, pour at right Angles their single Globules, into those much larger Veins. — *Statical Essays: Containing Haemastatics* by Stephen Hales, London, 1733.

# Editorials

## SUGGESTIONS FOR AUTHORS

The NORTH CAROLINA MEDICAL JOURNAL welcomes the contribution of original articles — scientific, historic and editorial — provided that they have either been published previously nor have they been simultaneously submitted for publication in other medical periodicals. Papers concerned with all aspects of the practice of medicine in North Carolina are particularly solicited.

### Manuscripts

Two copies of the complete manuscript including legends, tables, references and glossy prints should be submitted. All copies should be typed on standard size paper, double-spaced with margins at least 3 cm; photographic reproductions are preferred to carbon. A covering letter indicating the author responsible for correspondence and his address should accompany the manuscript.

### Titles and Authors' Names

These should be provided on a separate page in duplicate giving the full title of the paper; a shorter title for the table of contents; the author(s) first name(s), initial(s) and academic degree(s); the name of the department and institution where the work was done and the name and address of the author to whom requests for reprints should be directed.

### Abstracts

On a separate sheet, a double-spaced abstract of not more than 150 words should be submitted in duplicate. This should be factual telling of what was done, what was observed and what was concluded. A separate summary should not be provided.

### Abbreviations and Symbols

Usage recommended in *STYLE MANUAL FOR BIOLOGICAL JOURNALS* (3rd ed., 1972) should be followed insofar as possible. The first time an abbreviation is used, it should be explained. Generic names should be employed for drugs; if the author wishes to identify an agent by trade name, it should be inserted parenthetically at the first use of the term. Units of measurement should generally be metric including length and weight.

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References should be double-spaced and on a separate page(s) and should be numbered consecutively as they are cited in the text. The citations should conform to the style of the *INDEX MEDICUS* and the publi-

cations of the American Medical Association. The inclusive pages should be given but the number and day or month of the cited issue should not be included. Author(s) surname and initial(s); title and subtitle of the paper; journal or book in which it appeared; volume number, inclusive pagination and year for journal citation; title of book, editor if a collection, edition other than first, city, publisher, year and page of specific reference for books should be indicated. For example:

1. Villant GE, Sobowale NC, McArthur C: Some psychologic vulnerabilities of physicians. *N Engl J Med* 287:372-375, 1972.
2. Fox RC: *The Student-Physician: Introductory Studies in the Sociology of Medical Education*. Edited by Merton RK. Cambridge, Harvard University Press, 1957, pp 207-241.
3. Sniscak M: *Cumulative Cumulus Therapy*. Los Angeles, Exotic and Esoteric Press, 1984, p 81.

Unpublished data and personal communications should be alluded to in footnotes. Footnotes, however, should be limited and separated from the text by a line.

### Tables and Illustrations

These should be typed in double-space on separate sheets. Arabic numerals should be used and a legend for each table submitted. Tables should be as succinct as possible. Lines should be omitted and symbols for units given with the column heading. Other symbols should be explained at the bottom of the table. Illustrations should be glossy, black and white prints or line drawings. The name of the first author, the figure number and the top of the figure should be written lightly in pencil on the back of each print. Legends are to be typed consecutively for each figure on a separate sheet. If illustrations have appeared elsewhere, permission for reproduction from both the author and publisher must accompany the manuscript.

### Reviewing

All manuscripts are read by the editor. Most of them are also reviewed by members of the editorial board or other referees. Constructive comments by these reviewers will be returned to authors who will usually be notified within one month of receipt of the manuscript of editorial action. Editorial correspondence should be directed to:

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## DOWN HOME: ALCOHOL

*Alcohol will harm us brain cells,  
Poison us and harm us brain cells,  
So we smart, smart, smart little brain cells  
Say no, no, no more alcohol.*

—old WCTU song

Almost all cultures have developed an alcoholic beverage of their own for relaxation and ritual and have evolved their own measures for control of consumption. In traditional societies based on hunting, gathering or subsistence farming, biological necessity and often elaborate codes of behavior have more easily defined alcohol's place but industrial societies with large urban populations, automobiles and tax-eating bureaucracies continue to struggle to develop acceptable systems for regulation.

We only need to look at North Carolina to appreciate the complexities of the situation. Early settlers, mostly Scotch-Irish and German, brought their traditions and regional skills with them. From the Cape Fear to the Yadkin they distilled the "fiery usquebaugh" varying their formula with the grains they harvested and the fruits they picked, and shipped some of it to market. By the late 18th Century, regional patterns had been established. New England was engaged in the slave trade cultivating a triangle based on the movement of slaves to the Indies, molasses to Massachusetts and rum to Africa, Virginia planters sipped Madeira and the Baptist minister, Elijah Craig, had in the 1790s in Bourbon (now Scott) County, Kentucky, developed bourbon whiskey from corn. A few years later he introduced the charred keg and Kentucky's fate was sealed.

With the 19th Century, the Industrial Revolution came to a United States being made gradually smaller by the railroad which made the shipping of whiskey by the barrel much more profitable. By 1890 whiskey could be had at a dollar a gallon at any of Davie County's 15 commercial distilleries which shipped their products from the Mocksville depot.<sup>1</sup> But plentiful, cheap whiskey and religious revival are not congenial and the Temperance Movement arose to combat Demon Rum, cresting with Prohibition after World War I. But small operators, bootleggers, continued their efforts and North Carolina achieved preeminence for her moonshine. Wilkes, Robeson, Johnston and other counties similarly favored by geography — mountainous or swampy — took the lead shipping their leading product far and wide. Many subterfuges

were resorted to and many lawmen corrupted to keep white liquor flowing. One major distiller started raising chickens to ship as a camouflage and abandoned bootlegging when he found he was making a better profit selling the chickens.

When the noble experiment, Prohibition, failed, the dry forces in North Carolina were so strong that for a decade or so legal whiskey could not be bought west of the fall line. Moonshiner and minister joined in strange union to maintain the status quo. But World War I brought changes in attitude, liquor stores owned and operated by the state penetrated the Piedmont, quality control at the stills worsened as lead pipes were used instead of scarce copper, the cost of raw material rose, and, in Wilkes County, the chicken and egg industry offered better and safer jobs.

Still alcohol remains by far the number one drug problem in our state and nation despite concern about narcotics and Mr. Califano's campaign against nicotine and we are no nearer knowing what to do about it than did Benjamin Rush when not long before Elijah Craig he suggested that alcoholism might be a disease. Now Rev. Craig's co-religionists take a different position about alcohol than did he and most of us appreciate something of the emotional background of drinking and its physical consequences. Knowledge has not brought solutions but it has helped us to ask more sensible questions. Many of these questions are being answered because there are such projects as the University of North Carolina Center for Alcohol Studies under the direction of Dr. John A. Ewing. North Carolina is unique in the nation in that it has not yet permitted the sale of liquor by the drink and is also unique in that so many studies of importance about drinking are being carried out by the center. An excellent review of the problem, *Drinking, Alcohol in American Society — Issues and Current Research* edited by Ewing and Rouse, has just appeared and deserves careful study.<sup>2</sup> While there is expected variation in style natural to a work with many contributors and while there are some dull stretches, the book is generally well done and pertinent. Social, historical, economic, forensic, psychological and medical facets are examined in some depth and a trenchant summary is offered by the editors.

J.H.F.

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2. Ewing JA, Rouse BA: *Drinking, Alcohol in American Society — Issues and Current Research*. Chicago, Nelson-Hall, 1978, 443 pp.



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2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information."

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 Place: Duke University Marine Laboratory, Beaufort  
 Sponsor: Burroughs Wellcome Company  
 Fee: \$995

For Information: Dr. Eve MacDonald, Burroughs Wellcome Company, 3030 Cornwallis Road, Research Triangle Park, 27709

#### September 7-9

##### Family Medicine

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### September 8-9

Annual Meeting of the North Carolina Chapter of the American Academy of Pediatrics and the North Carolina Pediatric Society  
Place: Blockade Runner, Wrightsville Beach

For Information: David R. Williams, M.D., Chapter Chairman, Southgate Shopping Center, Thomasville 27360

#### September 13-15

##### Angus McBryde Perinatal Symposium

For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### September 14

##### Practicing Physicians Clinic

Place: Burroughs Wellcome Company

For Information: Stanley Grosshandler, M.D., Director of Continuing Education, Burroughs Wellcome Company, Research Triangle Park 27709

#### September 15-16

Walter L. Thomas Symposium on Gynecological Surgery and Malignancy

For Information: M. Henderson Rourke, Jr., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### September 20

##### New Developments in Renal and Hypertensive Disease

Place: Lee County Hospital, Sanford

Sponsor: Lee County Medical Society and Searle Labs

Credit: 3.5 hours

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#### September 26-28

##### Duke Cardiac Arrhythmia Seminar

Credit: 21 hours

For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### September 27-October 1

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Place: Mid-Pines Club, Southern Pines

Regular meetings will be scheduled for the chairmen and members of almost all regular Committees of the Medical Society; committee members should plan to be present.

For Information: William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

#### September 28-30

##### Seminar in Medicine

Place: Babcock Auditorium

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman-Gray School of Medicine, Winston-Salem 27103

#### September 28-October 1

##### Invitational Assembly for Advanced Urology on Urologic Malignancies

Place: Pinehurst Hotel and Country Club

Sponsors: Division of Urology, Duke University Medical Center

Fee: \$150

Credit: 16 hours; Category 1

For Information: Virginia Jordan, Assembly Secretary, P.O. Box 3343 Duke University Medical Center, Durham 27710

#### September 29-30

##### Ocuture Workshop

Fee: \$350; enrollment limited to 30 participants

For Information: David I. Eifrig, M.D., Room 617 Burnett-Womack Building 229-H, Chapel Hill 27514

#### October 2-6

##### Microvascular Surgery Workshop

Credit: 40 hours

For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### October 4-5

##### Seminar on Diabetes

Fee: None

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### October 4-5

##### Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital

Fee: None

Credit: 12 hours

For Information: Richard Kerecman, M.D., P.O. Box 795, Huntersville 28078

#### October 13-14

##### Alumni Scientific Session

Fee: None

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### October 16-18

##### North Carolina Office of Emergency Medical Services Annual Meeting

Place: Sheraton Inn, Charlotte

For Information: Mr. Chris Gentile, North Carolina Office of Emergency Medical Services, 1330 St. Mary's Street, Raleigh 27611

#### October 17-22

##### 30th Annual Workshop and Scientific Program of the Society for Clinical and Experimental Hypnosis

Place: Grove Park Inn, Asheville

Sponsors: Department of Psychiatry and the Department of Psychology of UNC and the Office of Continuing Education, UNC School of Medicine, and the School of Dentistry

For Information: Shirley Sanders, Ph.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### October 18

##### "Recent Developments in Gastroenterology"

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 5 hours, AMA Category 1;

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville, N.C. 27834

#### October 27-28

##### Cardiovascular Medicine and Surgery: A Harvey Quartercentenary Meeting

Credit: 11 hours

For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### November 8

##### "Practical Pediatrics"

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours, AMA Category 1;

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville, N.C. 27834

#### November 10

##### Seminar on Aging

Fee: \$35

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### November 16-18

##### 30th Annual Scientific Assembly of the North Carolina Academy of Family Physicians

ice: Sheraton Inn, Charlotte  
e: \$30

r Information: Mr. Edwin Davis, Executive Director, North  
Carolina Academy of Family Physicians, P.O. Drawer 11268,  
Raleigh 27604

#### November 29

nutrition in Medical Care 1978

ice: Lee County Hospital, Sanford

onsors: Lee County Medical Society and Eaton Laboratory

e: \$6.00 for non-M.D.'s

edit: 3.5 hours

r Information: R. S. Cline, M.D., Director of Continuing Medical  
Education, Lee County Hospital, Sanford 27330

#### December 1-2

merican College of Physicians — North Carolina Society of Inter-  
nal Medicine Annual Meeting

ice: Sheraton Inn, Charlotte

r Information: Norman H. Garrett, M.D., 1038 Professional Vil-  
lage, Greensboro 27401

#### December 2

egnancy, Birth, and Infancy: Origins of Attachment

r Information: Emery C. Miller, M.D., Associate Dean for Con-  
tinuing Education, Bowman Gray School of Medicine,  
Winston-Salem 27103

#### December 13

Office Gynecology"

ice: Pitt County Memorial Hospital, Greenville

ee: \$15

edit: 3 hours, AMA Category 1:

r Information: F. M. Simmons Patterson, M.D., Assistant Dean  
for Continuing Education, East Carolina University School of  
Medicine, Greenville, N.C. 27834

#### January 10

mmunological Aspects of Malignancy"

ice: Pitt County Memorial Hospital, Greenville

ee: \$15

edit: 3 hours, AMA Category 1:

r Information: F. M. Simmons Patterson, M.D., Assistant Dean  
for Continuing Education, East Carolina University School of  
Medicine, Greenville, N.C. 27834

#### January 26-27

inical Urology

ice: Babcock Auditorium

r Information: Emery C. Miller, M.D., Associate Dean for Con-  
tinuing Education, Bowman Gray School of Medicine,  
Winston-Salem 27103

### ITEMS OF SPECIAL INTEREST

#### August 21-23

dvanced Seminar on Ultrasound of the Abdomen and Obstetrics

ice: Dutch Inn, Buena Vista, Florida

onsors: Bowman Gray School of Medicine and Orlando Regional  
Medical Center, Inc.

ee: \$200

r Information: J. F. Martin, Director, Center for Medical Ul-  
trasound, Bowman Gray School of Medicine, Winston-Salem  
27103

#### October 23-27

urrent Concepts in Diagnostic Radiology

ice: Southampton Princess Hotel, Bermuda

ee: \$250

edit: 30 hours

r Information: Robert McLelland, M.D., Radiology — Box 3808,  
Duke University Medical Center, Durham 27710

#### October 26-29

nnual Fall Meeting, North Carolina Society of Internal Medicine

ice: Kiawah Island, South Carolina

r Information: Jack B. Hobson, M.D., 1351 Durwood Drive,  
Charlotte 28204

### PROGRAMS IN CONTIGUOUS STATES

#### September 11-12

ennessee Valley Medical Assembly

ice: Chattanooga Choo Choo, Convention and Concert Hall

LY 1978, NCMJ

For Information: Jerome H. Abramson, M.D., Chairman, 960 East  
Third Street, Suite 313, Chattanooga, Tennessee 37403

#### September 21-23

Cardiology for the Clinician

Place: Williamsburg, Virginia

Sponsor: Tidewater Chapter, American Heart Association

Fee: \$75

For Information: Tidewater Chapter, American Heart Association,  
891 Norfolk Square, Norfolk, Virginia 23502

### News Notes from the—

## EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

The Department of Family Medicine has received a \$463,380 grant from the Department of Health, Education and Welfare to support a graduate training program aimed at improving the quality of health care in eastern North Carolina.

Dr. James G. Jones, chairman of the ECU Department of Family Medicine, is director of the project which will provide professional training experience for family practice residents in their first, second and third year of training. Selection of residents for the program will target physicians who plan to practice in eastern North Carolina in an effort "to relieve the present critical physician manpower shortage."

The grant will also fund active research in family disease patterns seen by the family physician in rural settings. A director of research will coordinate data compiled by rural physicians and ECU faculty members.

Grant funds will also be used to support continuing education programs for rural family physicians in the region. Physicians will be given the opportunity to attend a "mini-residency" at the Eastern Carolina Family Practice Center, the primary care facility operated by the medical school's Department of Family Medicine.

Seven family practice residents are now training at the center. The grant will assist the medical school in reaching its goal of 36 residents at the center by 1981.

\* \* \*

The N.C. Department of Human Resources has designated ECU's Department of Obstetrics and Gynecology as a cancer diagnosis and treatment center for 29 counties in eastern North Carolina. Patients will be seen at the department's facilities at Pitt County Memorial Hospital.

\* \* \*

Dr. Edward M. Lieberman, associate professor of physiology, has received a \$74,879 research grant from the National Science Foundation, Division of Behavioral and Neural Sciences. Lieberman is studying the movement of sodium and potassium in nerve membranes in the giant nerve of the crayfish.



Lieberman says the two-year project may provide insight into several neural problems including epilepsy.

\* \* \*

Dr. Robert S. Fulghum, associate professor of microbiology, has been elected secretary-treasurer of the North Carolina branch of the American Society of Microbiology.

\* \* \*

Dr. Lawrence S. Harris, forensic pathologist, led a session on "Natural, Unexpected Death" at the International Association of Forensic Scientists in Wichita, Kan., during May.

#### News Notes from the—

### BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The Bowman Gray School of Medicine will begin a new education program, a Neurological and Neurosurgical Nurse Specialist Program, in the fall.

Four registered nurses will be enrolled in the program's first class, which begins studies Sept. 5.

The program's aim is to provide nurses with the additional training they will need to play a greatly expanded role in the care of patients with neurological and neurosurgical problems.

The eight-month program will concentrate on the common neurological and neurosurgical problems of patients as well as the usual treatment and management of those patients. The nurses will serve in doctors' offices and in hospitals before graduating.

\* \* \*

The promotions of 30 fulltime and eight part-time Bowman Gray faculty members have been announced.

Promoted to professor are Dr. Lawrence R. DeChatelet, biochemistry; Dr. John L. Fishburne, obstetrics and gynecology; Dr. David L. Kelly, surgery (neurosurgery); and Dr. W. Joseph May, obstetrics and gynecology.

Receiving promotions to associate professor were Dr. James E. Crowe, radiology; Dr. Kenneth E. Ekstrand, radiology; Dr. Frederick W. Glass, surgery (emergency medicine); Dr. Howard D. Homesley, obstetrics and gynecology; Dr. C. Patrick McGraw, neurology research; Dr. Hyman B. Muss, medicine (hematology/oncology); Dr. Lawrence L. Rudel, comparative medicine; Dr. Alfred J. Rufty, medicine; Dr. Zakariya K. Shihabi, pathology; Dr. James E. Turner, anatomy; Dr. William D. Wagner, comparative medicine; Dr. Benedict L. Wasilaskas, pathol-

#### Brief Summary of Prescribing Information Combined TEGOPEN® (cloxacillin sodium) Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

**N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.**

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.



BRISTOL LABORATORIES  
Division of Bristol-Myers Company  
Syracuse, New York 13201

# IN THE NORTH CAROLINA AREA, STAPH RESISTANCE HAS NOW REACHED 72%.\*

\*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

## TEGOPEN<sup>®</sup> (cloxacillin sodium)

“THE PENICILLIN OF TODAY”

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary  
for prescribing information.



ogy; and Dr. Douglas R. White, medicine (hematology/oncology).

Promoted to the rank of assistant professor are Dr. Frances G. Baird, pathology; Dr. John D. Davis, medicine (rheumatology); Dr. Stephen W. Hebert, psychiatry; Dr. Thomas H. Hunt, radiology; Dr. James Ray Israel, psychiatry; Dr. Alan Klein, radiology; Dr. James D. Mattox, psychiatry; Dr. Joe M. McWhorter, surgery; Dr. Lewis H. Nelson, obstetrics and gynecology; Dr. David J. Ott, radiology; Dr. Edward J. Pisko, medicine (rheumatology); Dr. Mary Ann H. Taylor, community medicine; and Dr. Theodore Wendel Jr., physiology/pharmacology.

Part-time faculty receiving promotions are Dr. Willis J. Grant III, clinical associate professor of psychiatry; Dr. Ali Jarrahi, clinical associate professor of psychiatry; Dr. George Podgorny, clinical associate professor of surgery (emergency medicine); Dr. Jerry L. Bennett, clinical assistant professor of pediatrics; Dr. James F. Earnhardt, clinical assistant professor of pediatrics; Dr. John C. Faris, clinical assistant professor of pediatrics; and Dr. William F. Sayers, clinical assistant professor of pediatrics.

\* \* \*

Five members of the Bowman Gray faculty have received Faculty Foreign Travel Awards, which are presented by the dean on the recommendation of the school's Intramural Research Support Committee.

Dr. George J. Doellgast, assistant professor of biochemistry, will attend a conference of the International Research Group for Carcinoembryonic Proteins, Sept. 17-22 at Marburg, West Germany. Dr. Phillip M. Hutchins, associate professor of physiology, will attend the 10th World Conference of the European Society of Micro-circulation, starting Oct. 25 on the island of Sardinia. Dr. Christine A. Johnson, associate professor of pediatrics, was in Paris July 23-29 attending the Joint Congress of the International Society of Hematology and the International Society of Blood Transfusion. Also going to Paris in July were Dr. David K. Sundberg, assistant professor of physiology, and Dr. Theodore Wendel Jr., assistant professor of physiology/pharmacology. They attended the 7th International Conference of Pharmacology, July 16-21. Wendel also attended a symposium on the Pathophysiology, Biochemistry and Pharmacology of Cerebrovascular Disease, July 23-26 in Rheims, France.

\* \* \*

The first annual James E. Chapman Memorial Award presented by Bowman Gray's Department of Obstetrics and Gynecology has gone to Dr. Joel B. Miller.

The award, which honors the school's outstanding resident in Ob/Gyn, was presented during the Frank R. Lock Symposium.

Dr. James E. Chapman was a 1972 graduate of Bowman Gray and practiced obstetrics and gynecology in Winston-Salem until his death in 1977.

Miller, a chief resident in Ob/Gyn, began his residency training in 1974. He will soon establish a private practice in Hickory.

\* \* \*

Eugene H. Paschold of Albemarle and Dr. H. O. Goodman received top honors during Bowman Gray's annual awards ceremony.

Paschold, a senior medical student who received the M.D. degree May 15, was presented the Faculty Award, the highest honor the Bowman Gray faculty can bestow on a student. Goodman, professor of medical genetics, received the Award for Teaching Excellence, given by students, faculty and medical school administration. He also was presented a Basic Science Teaching Award.

Paschold also was the recipient of the Upjohn Achievement Award, given by the graduating class to a classmate who "possesses those qualities which enable him to become the complete physician."

A Basic Science Teaching Award also was presented to Dr. Lawrence R. DeChatelet, professor of biochemistry.

The Annie J. Covington Memorial Award, for excellence in the study of cardiology, was given to Stanley Neal Tennant of St. Mary's, W. Va. Phillip O. Katz of New York City received the C. B. Dean Memorial Award for outstanding performance in the study of clinical oncology.

The Pediatric Merit Award went to Susan R. Levy of Orange, Conn., for exceptional ability and interest in pediatrics. Marlene F. Kaniuk of Neosho, Mo., received the Obstetrics-Gynecology Merit Award. The Robert P. Vidinghoff Memorial Award went to Lee A. Beatty of Mount Holly, for demonstrating the greatest aptitude and devotion to family practice.

Dr. Samuel Pegram, an instructor in internal medicine, and Dr. Ralph Caruana, a resident in internal medicine, received House Officer Teaching Awards from the senior class.

Dr. Gerald R. Friedland, professor of radiology, and Dr. N. Sheldon Skinner, professor of medicine and physiology, received Clinical Faculty Teaching Excellence Awards.

\* \* \*

Dr. Bruce C. Walley, a four-year house officer in general surgery, has won first prize in a scientific competition sponsored by the North Carolina Chapter of the American College of Surgeons.

He won the Resident's Forum competition with a scientific paper entitled "Recent Concepts in the Pathogenesis and Treatment of Ascites."

\* \* \*

Dr. Joel L. Edwards, a resident in family medicine, is the winner of a 1978 Mead Johnson Award for Graduate Training in Family Practice. He is one of 18 recipients of the \$1,200 award presented by the American Academy of Family Physicians.

The awards are given annually to aid young physi-



ians planning careers as family doctors.  
Edwards is a second-year resident in Bowman Gray's family practice program.

\* \* \*

Dr. Eben Alexander, professor of neurosurgery, has been awarded honorary membership in the University Association of Emergency Medicine.

\* \* \*

Dr. F. A. Blount, assistant professor of pediatrics, has been re-elected to represent the North Carolina Medical Society on the board of trustees of North Carolina Blue Cross/Blue Shield.

\* \* \*

Dr. Robert J. Cowan, associate professor of radiology, was elected chairman of the Section on Nuclear Medicine at the North Carolina Medical Society's annual meeting.

\* \* \*

Dr. Courtland H. Davis Jr., professor of neurosurgery, has been appointed to the nominating committee for the Neurosurgical Society of America.

\* \* \*

Dr. Frederick W. Glass, associate professor of surgery, has been appointed to the Graduate/Undergraduate Education Committee of the American College of Emergency Physicians.

\* \* \*

The University of Adelaide School of Medicine in Australia has named Dr. John P. Gusdon Jr. a Doctoral Examiner for reproductive immunology. Gusdon is professor of obstetrics and gynecology.

\* \* \*

Dr. Frederic R. Kahl, assistant professor of medicine, has been elected to the board of directors of the North Carolina Heart Association.

\* \* \*

Dr. James F. Martin, professor of medical sonics, has been reappointed as a member of the Committee on Education and Training of the Commission on Ultrasound for 1978-79.

\* \* \*

Dr. William M. McKinney, professor of neurology, has been reappointed co-chairman for the Piedmont Health Systems Agency Ultrasound Review Criteria Task Force.

\* \* \*

Dr. George D. Rovere, associate professor of orthopedic surgery, has been appointed to the Sports Medicine Advisory Commission of the State Department of Public Instruction for a new three-year term.

Dr. Earl Schwartz, instructor in surgery, was elected chairman of the North Carolina Medical Society Section of Emergency Medicine.

\* \* \*

Dr. Charles L. Spurr, professor of medicine, was elected as a North Carolina delegate to the American Cancer Society.

\* \* \*

Dr. J. M. Sterchi, assistant professor of surgery, has been appointed Liaison Fellow and North Carolina chairman to the Commission on Cancer for a four-year term.

\* \* \*

Dr. Joseph Whitley, professor of radiology, was named president-elect of the Association of University Radiologists at the association's annual meeting.

#### News Notes from the

### UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

One of the world's foremost kidney researchers, Dr. Carl W. Gottschalk of UNC-CH, has won the O. Max Gardner Award for 1978.

The award, the only statewide honor given by the UNC Board of Governors, is presented annually to a faculty member of the 16-campus UNC system who, during the current scholastic year, has made the greatest contribution to mankind.

Gottschalk is Kenan Professor of Medicine and Physiology in the School of Medicine. He also is a Career Investigator of the American Heart Association and has been influential in national planning for dialysis and kidney transplantation treatment of patients with kidney disease.

Gottschalk has earned an international reputation for the development of micropuncture techniques that have shed light on how the kidney functions in man in both normal and disease states.

\* \* \*

More than a quarter of a century ago three scientists developed a simple laboratory test that made it possible for the first time to diagnose and treat the various forms of hemophilia. The partial thromboplastin time (PTT) test, developed at the UNC-CH School of Medicine in 1953, represented a major breakthrough in the understanding of blood coagulation and bleeding disorders. The test's developers, Drs. Robert Langdell, Robert Wagner and Kenneth Brinkhous, were honored May 18 at a special commemorative seminar marking the 25th anniversary of the develop-

ment of the test. Brinkhous, who is Alumni Distinguished Professor of Pathology, chaired the pathology department for more than 26 years before stepping down in 1973 to return to fulltime teaching and research. Wagoner and Langdell, both professors of pathology, also have been associated with the School of Medicine since the very early 1950s.

\* \* \*

#### *Retirements*

Dr. J. Logan Irvin, Kenan Professor of Biochemistry and Nutrition, has retired as chairman of the Department of Biochemistry and Nutrition to return to fulltime teaching and research.

#### *Promotions*

Dr. Merrel D. Flair has been promoted to professor of psychology, Department of Psychiatry. Dr. Eugene S. Mayer, Departments of Medicine and Family Medicine, has also been promoted to professor.

Promoted to associate professor are: Dr. Nortin M. Hadler, Departments of Medicine and Bacteriology and Immunology; Dr. John C. Hisley, Department of Obstetrics and Gynecology; Drs. Eng-Shang Huang and Henry R. Lesesne, Department of Medicine; and Dr. J. David Leander, Department of Pharmacology. Bozman R. Reeves Jr., Department of Medicine, was promoted to assistant professor in April.

Other promotions: Dr. Stanley R. Mandel and Dr. Herbert J. Proctor, professors of surgery, and Dr. William H. Bowers, Dr. Robert D. Croom III, Dr. Charles A. Herbst Jr., and Dr. Noel B. McDevitt, associate professors of surgery.

#### *Appointments*

Four new faculty members have been appointed to the School of Medicine: Drs. Robert H. Fletcher and Suzanne W. Fletcher, associate professors, Department of Medicine; Gladys N. Masagatani, associate professor, Department of Medical Allied Health Professions; and John A. Messenheimer, assistant professor, Departments of Neurology and Medicine.

Robert Fletcher, an assistant professor at McGill University Medical School since 1973, also will direct the clinical scholars program at UNC-CH. He earned his B.A. from Wesleyan University, M.D. from Harvard and M.Sc. from Johns Hopkins. Suzanne Fletcher, an assistant professor at McGill since 1973, also will direct the primary care clinic. She received her B.A. from Swarthmore College and M.D. from Harvard.

Masagatani comes to Chapel Hill from the University of Pennsylvania where she has been assistant professor in the School of Allied Medical Professions since 1972. A graduate of the University of Hawaii, she earned her certificate in occupational therapy from Wayne State University and master of education from the University of Florida.

Messenheimer has been research associate in EEG in the Department of Neurology at the University of Virginia since 1977. He received his B.S. from Mount Union College and M.D. from the Johns Hopkins.

Dr. Eszter B. Kokas, professor emeritus of physiology, received the Golden Diploma Award during a May ceremony at Medical University in Debrecen, Hungary. The presentation commemorated the 50th anniversary of the awarding of the M.D. degree to Kokas from Medical University. A native of Hungary, she is a research specialist in the physiology of the digestive tract. After earning her M.D., she received special training in physiology under Hungarian State Fellowships in Switzerland, Berlin, London and Paris. In 1956, she became the first woman in Hungary to earn the equivalent of a Ph.D. in the medical sciences. She came to UNC-CH in 1960 as an assistant professor and retired in 1976.

\* \* \*

Seven people, including six alumni of the University of North Carolina, received the School of Medicine's highest honor, the Faculty-Alumni Distinguished Service Awards.

Those honored were: Dr. Carl E. Anderson, professor emeritus of biochemistry and nutrition at UNC-CH; Dr. William A. H. Gannt, associate professor of psychiatry emeritus at Johns Hopkins University; Dr. Luther W. Kelly Jr., president of the Nalle Clinic in Charlotte; Hector MacLean, chairman and chief executive of the Southern National Bank of North Carolina; Dr. Frank R. Reynolds, a Wilmington pediatrician; Dr. William P. Richardson, retired professor of preventive medicine; and Dr. William G. Thurman, a pediatrician and provost of the University of Oklahoma Health Sciences Center.

Established in 1955 on the 75th anniversary of the founding of the UNC-CH medical school, the Distinguished Service Awards recognize individuals whose careers and contributions have added to the prestige of the university and its medical school.

Awards and citations were presented by Dr. Christopher C. Fordham III, dean of the school of medicine, during the annual alumni banquet at the Carolina Inn.

\* \* \*

Dr. W. Reece Berryhill, dean emeritus, was honored recently by the North Carolina Academy of Family Physicians for his 30 years of support of family practice. He was among a group of physicians who gathered in Greensboro in 1947 to form a family practice organization. As an honorary member he has continued to support the academy and its programs of primary care education for families throughout the state.

Berryhill also received the Jefferson Award and Laureate in Education from the North Carolina Association of the Professions at its 15th annual meeting in March. The newly-created award was presented to seven people cited as "outstanding professional leaders and educators" at North Carolina colleges and universities which train students for professional careers. Recipients also receive honorary membership in the North Carolina Association of the Professions.



E. Wayne Robinson, associate director of pastoral care at North Carolina Memorial Hospital, has been certified as a chaplain supervisor by the National Certification Committee of the Association for Clinical Pastoral Education. This certification is the highest awarded by the association.

\* \* \*

Dr. John T. Sessions Jr., professor of medicine and specialist in gastroenterology, was named first recipient of the Distinguished Faculty Award.

The award was initiated this year by the Medical Alumni Association to recognize fulltime faculty members who give of their time to the alumni and to the state. It is awarded for dedication to the medical profession, excellence in teaching, leadership in the school and medicine and meritorious service to alumni.

Sessions recently chaired a panel which testified at Senate Appropriations Committee hearings. The panel, which included representatives of the National Foundation for Ileitis and Colitis, the American Gastroenterological Association, the Endocrine Society, the Renal Physicians Association and the National Academy of Dermatology, sought funding for the research and training programs of the National Institute of Arthritis, Metabolism and Digestive Diseases.

\* \* \*

Dr. William G. Thomas, associate professor of

surgery, division of otolaryngology (audiology) and director of the Hearing and Speech Center, attended the board meeting of the Council on Accreditation in Occupational Hearing Conservation and presented "Hearing Conservation Programs Today" at the National Noise and Vibration Control Conference in Chicago.

Thomas also attended the annual meeting of the North Carolina Speech, Hearing and Language Association in Greensboro. He presided over one session, "Benefits of Professional Associations," and presented "Diagnostic Implications of Brain-Stem Evoked Responses" during another session.

\* \* \*

Dr. Michael McGinnis, assistant professor of bacteriology and immunology and associate director of clinical microbiology laboratories, made a presentation at the First International Histoplasmosis Conference in Atlanta.

\* \* \*

Samuel Hitt, director of the Health Sciences Library, is president-elect of the newly-formed Association of Academic Health Sciences Library Directors.

\* \* \*

Dr. Joseph A. Buckwalter, professor of surgery, presented "Surgical Treatment of Morbid Obesity" to the UNC Medical Alumni — Surgical Grand Rounds



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on April 8, and to the Wisconsin Surgical Club, Chapel Hill, April 17. He presented "Surgical Treatment of Thyroid Disease" to the North Carolina Surgical Society in Southern Pines in April.

\* \* \*

Dr. Larry R. Churchill, assistant professor of medical studies, and Dr. James A. Bryan II, professor of medicine, conducted a Clinical Humanities Seminar on "Compliance and Control" at Milton S. Hershey Medical Center, Pennsylvania State University.

\* \* \*

Evelyn B. McCarthy, educational planning and development consultant in the Office of Medical Studies, presented "Minority Admissions and Retention — A Look at the Issues" at the 1978 annual convention of the American Medical Student Association in Atlanta. She also chaired a committee meeting on the Task Force on Student Retention of the Southern Regional Group on Medical Education in Atlanta.

\* \* \*

Dr. Steven A. Cohen-Cole, instructor in psychiatry, and Dr. Charles P. Friedman, Office of Medical Studies, wrote a paper presented by Cohen-Cole at the recent meeting of the American Psychosomatic Society in Washington. Friedman also presented a paper at a meeting of the North American Primary Care Research Group in Toronto.

\* \* \*

Dr. Kenneth R. Haslam, assistant professor of anesthesiology and director of medical engineering, attended the annual meeting of the Association for the Advancement of Medical Instrumentation in Washington. Haslam is a member of the Board of Examiners for Biomedical Equipment Technicians.

\* \* \*

Dr. Geoffrey Houghton, profession of bacteriology and immunology, has received a \$25,000 American Cancer Society research development grant to continue studies of an antiserum that, in mice, attacks only lymphoma tumor cells.

\* \* \*

Faculty presenting papers at the 11th Annual Symposium on Malignant Diseases included: Dr. James F. Newsome, professor of surgery, "Management of Unusual Gastrointestinal Tumor"; Dr. Michael R. Swift, associate professor of medicine, "Genetic Predisposition: Clues to Early Diagnosis"; Dr. John T. Sessions Jr., professor of medicine, "The Role of the Radiologist in Diagnosis"; Dr. Edward V. Staab, professor of radiology, "Application of Ultrasonography and CAT Scan"; Dr. Edward E. Rogoff, assistant professor of radiology, "Adjuvant Radiotherapy" and Dr. Robert L. Capizzi, professor of medicine, "Management of Recurrent Gastrointestinal Carcinoma."

The Health Services Research Center has received a five-year, \$84,791 grant from the W. K. Kellogg Foundation of Battle Creek, Michigan.

The funds will be used to evaluate a national demonstration program on the use of specially trained dental assistants in private practice and to help disseminate the findings.

Dr. Gordon H. DeFries, director of the UNC-CH Health Services Research Center, will chair the national advisory committee to the Kellogg Foundation that will oversee and evaluate the national demonstration program.

The purpose of the demonstration program is to see if dental assistants trained to help perform selected dental tasks formerly done only by the dentist increase the productivity of private dental practices.

\* \* \*

The Clinical Research Unit at North Carolina Memorial Hospital has received a three-year renewal of funding by the National Institutes of Health. Support will be continued at approximately the current level of \$800,000 a year.

Established in 1962 and operated by the School of Medicine, the unit is one of 83 federally-supported centers for clinical investigation. It is a highly specialized, 16-bed patient care unit in which medical scientists study diseases under carefully controlled conditions. The objectives are to discover the causes of complicated disorders and to develop improved treatment methods.

\* \* \*

Faculty members who presented papers at the Fourth Annual Postgraduate Course in Perinatology include: Dr. Geoffrey Sher, assistant professor of ob-gyn, "Management of Premature Labor and Delivery"; Dr. Edward E. Lawson, assistant professor of pediatrics, "The Early Management of Premature Infants"; Dr. Lamar E. V. Ekbladh, assistant professor of ob-gyn, and Dr. Ross L. Vaughn, assistant professor of pediatrics, Wake County Hospital, who led a panel discussion on "Transport: Who, When and How?"; Dr. Dwight A. Powell, assistant professor of pediatrics, "Neonatal Sepsis: Diagnosis and Management"; Dr. Luther M. Talbert, professor of ob-gyn, "Management of Thyroid Disease in Pregnancy" and Dr. A. Joseph D'Ercole, assistant professor of pediatrics, "Neonatal Thyroid Screening."

Patient management seminar speakers included Sher and Dr. James D. Thullen, assistant professor of pediatrics, Wake County Hospital, "Diabetic Pregnancy and the Infant of the Diabetic Mother"; Dr. Ernest N. Kraybill, associate professor of pediatrics and director of nurseries, "Rh Incompatibility Mother and Infant"; D'Ercole, "Hypertensive Disease in Pregnancy and Sequelae in the Newborn"; Dr. William N. P. Herbert, assistant professor of ob-gyn and Lawson, "Third Trimester Bleeding" and Dr. Arthur S. Aylsworth, assistant professor of pediatrics, Ekbladh and Dr. Rosemary S. Hunter, assistant

professor of psychiatry and pediatrics, "Congenital anomalies: Genetic and Psychological Counseling."

#### News Notes from the—

### DUKE UNIVERSITY MEDICAL CENTER

Members of this year's medical school graduating class selected Dr. Suydam Osterhout, professor of microbiology, as the recipient of the second annual Thomas D. Kinney Award for Excellence in Teaching.

Osterhout, who also is associate dean for admissions, is a 1945 graduate of Princeton and received his M.D. degree from Duke in 1949.

The Kinney Award was established in the spring of 1977 by the Davison Society, Duke's medical student government organization. It honors the late Dr. Kinney, former chairman of the Department of Pathology and past director of medical and allied health education.

The award was presented during the school's traditional Hippocratic Oath Ceremony.

\* \* \*

A number of student awards also were given at the Hippocratic Oath Ceremony and included:

The Sandoz Award of \$100 and a plaque to Stephen Arnold Wank for biochemical research. . . . The Upjohn Award to Eugene Wilson Griffin III for commitment to the Primary Care Program. . . . The Lange Medical Publication Award of four books to Robert McKinnon Califf and William Haywood Bobbitt III. . . . The American Medical Women's Association Achievement Citation to Marianne Jackson, Peggy Susan Lindsey and Linda Celeste Robb-Nicholson. . . . the Markee Memorial Award of \$200, a medal and certificate to Frank John Suslavich Jr. as the outstanding anatomy student in the first-year class. . . . Citations for having won Davison Scholarship travel awards to Jodelle Sue Groeneveld (1976) and Michael Robert Gorman (1977). . . . Recognition for earning both M.D. and Ph.D. degrees in six years to Bert Alton Brantley Jr., Steven Robert Butler, Clinton Hubert Joiner, John Carson Hay Steele Jr., Stephen Young Wilkerson and Lewis Thomas Williams. . . . The Trent Prize of \$100 and a certificate to Dale Bredezen for a paper on the history of psychosurgery. . . . C. V. Mosby Book Awards of books and a certificate for service to Jonca Camille Bull, Joan Sanford Henderson, Kurt Douglass Newman, Lyn Alice Sedwick and Charles Lutin.

\* \* \*

A Duke scientist has received a \$344,500 grant from the National Institutes of Health (NIH) to continue

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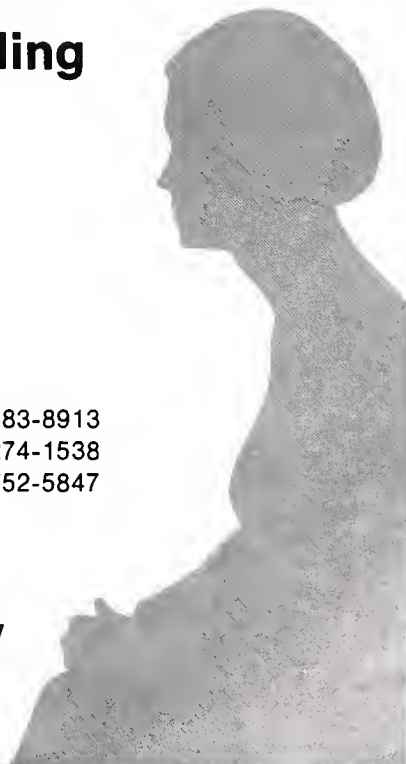
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The four-year grant renewal was awarded to Dr. Stuart Handwerger, associate professor of pediatrics.

Handwerger and his colleagues, Drs. Lee Tyrey and M. Carlyle Crenshaw, will be investigating the effects of placental lactogen, a hormone produced by the placenta, on fetal growth and metabolism. They also will try to determine factors that control the synthesis and secretion of placental lactogen.

Crenshaw and Tyrey are professor and associate professor, respectively, of obstetrics and gynecology.

\* \* \*

Dr. Marianne S. Breslin, associate professor of psychiatry and head of the Division of Psychosomatic Medicine, is the new vice president of the North Carolina Neuropsychiatric Association, a district branch of the American Psychiatric Association.

\* \* \*

A third-year medical student has been spending the summer taking a close look at socialized medicine. Timothy R. Harward was given a \$1,000 award by the International College of Surgeons, making possible three months' study at Oxford University in England.

At Oxford, Harward is studying general surgery under Prof. Peter Morris, chairman of surgery at Radcliffe Infirmary.

\* \* \*

Students in the School of Medicine have selected this year's "Golden Apple Award" winners.

They are Dr. Samuel L. Katz, professor and chairman of pediatrics; Dr. Peter C. Burger, assistant professor of pathology; and Dr. Ralph Corey, chief resident in internal medicine.

The three were selected to receive Golden Apples in the clinical sciences, basic sciences and house staff categories, respectively.

\* \* \*

Dr. William W. Johnston, professor of pathology

and director of the Division of Cytopathology, was visiting professor at The Johns Hopkins University Department of Pathology April 15-20. He spoke on the detection of lung cancer and described diseases that mimic lung cancer.

\* \* \*

Dr. Ronald P. Krueger, a specialist in pediatric nephrology and urology at Duke, has received \$30,000 American Urologic Association Scholarship Award. The award, granted over a two-year period, provided by the Burroughs Wellcome Fund and will go to finance study and research.

This summer Krueger will begin a year's sabbatical leave at the Hospital for Sick Children in Toronto. An assistant professor of pediatrics and urology, Krueger is a pediatric nephrology consultant for Project Hospital and has been working with a group of Polish physicians both at Duke and in Krakow in preparation for assisting them with their first pediatric kidney transplant next year.

\* \* \*

Dr. William C. Hall finished 75th out of about 4,000 runners who entered the Boston Marathon. Hall's time in the 26 mile, 385 yard marathon was two hours, 25 minutes and 27 seconds (2:25:27).

An associate professor of anatomy, the 37-year-old Hall improved his position by 33 and his speed by nine minutes and seven seconds over his performance in the 1977 marathon when he finished 108th with a time of 2:34:34.

\* \* \*

Seven assistant professors have been appointed to the medical center faculty.

Named in the Department of Anatomy were Dr. Nell B. Cant, Richard B. Marchase and Frederick Schachat. Drs. Jennifer Horner, John Denis Luc and John E. Riski are new members of the Department of Surgery, and Dr. P. Michael Conn has joined the Department of Pharmacology.

---

Now by this means the Blood has a much freer Passage thro' the Lungs, where it is requisite for it to move with much greater Velocity than in other parts of the Body. Whereas in some if not all the Muscles, by entering the finer capillary Vessels at right Angles its Velocity is much retarded. I have observed that where a long capillary Artery branches off at an acute Angle, that there the Velocity of the Blood is many times greater, than where it branches off at right Angles, which plainly shews the great Degree of Retardation which the Blood suffers by its passing off at right Angles. And this Retardation, which was necessary in order to prevent the Blood's passing too freely, must be very considerable, where it successively passes several times at right Angles, as in the Bowels, Urine and Gall Bladders and other parts of the Body. On which account, as well as on account of the greater Length of the Arteries, a greater impelling Force was necessary to drive the Blood thro' the great Artery, and its several Branches than thro' the Lungs; and accordingly the left Ventricle of the Heart is made much stronger, thereby to impel the Blood with a greater Force than the right Ventricle does. — *Statical Essays; Containing Haemastatics* by Stephen Hales, London, 1733.



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# Month in Washington

The Health, Education and Welfare Department has asked the Justice Department to delay granting the nation's hospitals an exemption under the antitrust laws in order to carry out their voluntary cost containment effort.

John Alexander McMahon, AHA President, said that "it seems passing strange that HEW would undermine and even try to undercut our voluntary effort" by taking this position before Justice.

HEW told Justice in a letter there may be "a serious lack of public accountability and public participation in the voluntary effort conducted by the AHA, the American Medical Association and the Federation of American Hospitals.

HEW General Counsel wrote Justice that the voluntary effort might discriminate against smaller community hospitals and health maintenance organizations and also might work to hold down wages of hospital workers.

HEW has been hostile to the voluntary effort from the outset, contending that only mandatory federal controls as embodied in the Administration hospital cost containment program are the answer to inflation in hospital costs.

Meanwhile, the war of words on the Administration's controversial hospital revenue control plan heightened when HEW Secretary Joseph Califano charged that opponents of the plan are "crowding the halls of Congress" and "lobbying for runaway inflation."

"Even Lloyds of London backed by the United States mint could not afford to insure the existing profligate, inflationary health care industry," he said in a speech.

The vote on hospital controls in the House Commerce Committee is considered the key to the fate of the Administration's plan. President Carter has dispatched a letter to every member of the Committee urging them to back the Administration's plan.

Stuart Eizenstat, White House Domestic Affairs Chief, said the issue before the Committee was "whether we have as a nation the capability of facing up to the inflation problem."

\* \* \*

HEW is preparing to launch a program to encourage second opinions for surgery for Medicare/Medicaid patients. Patient pamphlets, physician enrollment, and radio-television ads ("second opinion — it's good for you") are projected.

"List developers" will set up lists of physicians willing to participate in a second opinion (SO) program, on patient request. "List holders" will operate telephone referral centers to which patients may apply for the names of participating physicians.

Developers will query physicians as to their willingness to participate, inform them of any "ground rules," and develop the lists, with appropriate information such as willingness to accept Medicaid patients.

The Health Care Financing Administration of the HEW Department believes professional standards review organizations (PSROs) are the logical units to handle the "list" functions. However, carriers and medical societies also are eligible.

Public campaigns will begin soon and will consist of brief TV spot announcements and longer radio "dramas" on "SO" which will be distributed to stations. Five million leaflets will be distributed with Social Security checks in selected areas. A national "hot-line" (800 number) will be established, probably with the PSRO clearinghouse in Rockville, Md.

Once the program is operational, callers will be given the name of two or three physicians who are willing to accept requests for second opinion consultation. Wherever feasible, the referral center will try to give the names of physicians with some special competence in the type of condition for which surgery has been recommended, HEW said.

For Medicare patients, the program will pay for the second opinion as for other consultations, at 80% of the "reasonable charge," while Medicaid participation and payment, thus far, is at the option of the individual state. This may pose a tough problem in some states.

As presently planned, use of the "second opinion" will be at the patient's option, and the second opinion will not control payment for services.

The "SO" program is based on the assumption that second opinions will forestall unnecessary surgery.

\* \* \*

Attacking "federal bossism" in health planning, an AMA official has said that planning must be flexible and "cannot be stereotyped from federal blueprints."

Frank J. Jirka, Jr., M.D., Vice Chairman of the AMA Board of Trustees, told a National Journal Conference on Health Policy that the best way to uphold availability and quality is to have planning decisions made at the local level. "Practicing physicians



should be well represented on planning bodies," Dr. Jirka said.

The planning guidelines recently put into effect are still mandatory . . . "in a way that runs counter to Congressional intent," he declared, and "complaints about the guidelines keep pouring into HEW headquarters . . . and now exceed 70,000." The standards "ignore many of the realities of medical care . . . and could cause substantial disruption in the accessibility and provision of health services," according to Dr. Jirka.

Although the HEW Secretary has given assurances against the closing of existent hospitals, "they are not borne out in the body of the guidelines," Dr. Jirka noted. "Even the expansion of physicians' offices and their equipment would be affected if Congress decides to include them in the planning act's certificate-of-need provisions," he said.

"There is as yet little evidence to support the notion that certificate of need results in significant cost savings," said Dr. Jirka. "And if it doesn't, why badger doctor's offices with it?"

\* \* \*

The AMA has cautioned against precipitous or unilateral government action in the field of computer technology for medical purposes. Such intrusion "might retard the momentum" developed with computers, the AMA told a House science subcommittee. H. Phillip Hampton, M.D., speaking for the Association, said "the primary thrust in the growing and changing field of computer technology has been and should remain in the private sector."

However, Dr. Hampton said, the federal government has an important role in assisting the development of technology and "should remain a stabilizing influence . . . such a stable influence can be best achieved by continuing to fund substantial research and development projects, by insuring only necessary requirements on the individuals and organizations involved in medical and other health services delivery at the local level."

"Computers should improve methodologies of prevention and treatment of diseases by increasing the level of preventive, diagnostic and therapeutic medical skills; and make the skills accessible by providing them at a cost within the financial reach of the patient," Dr. Hampton said.

"Since many physicians are reaching the point of overload in trying to maintain and improve patient care while complying with increased administrative and governmental demands, use of computer technology has become more attractive," he noted.

Computers have "an enormous potential in improving patient care, in creation, storage, maintenance and retrieval of medical records, in improving preventative, diagnostic and therapeutic skills, in reducing the rate of increasing costs, in improving facility and personnel utilization and in improving office management," the AMA spokesman testified.

The Chairman of the Council on Economic Advisors told the Administration that it is "unrealistic at this time to propose a national health insurance (NHI) package which mandates universal and comprehensive low-dollar coverage."

In paper on NHI prepared for Presidential review, Charles Schultze said comprehensive coverage would "stretch thin" the health sector resources and thus exacerbate inflation. A sweeping NHI program would tend to "override completely" consumer latitude in choosing between health care and other goods and services such as housing and education, he said.

The paper said the CEA believes the Administration's NHI plan should include better and "more rational" health assistance for the poor, and catastrophic coverage for lower and middle-class families. Those objectives should be financed out of general revenues, CEA said, but without public reinsurance of private catastrophic programs except, perhaps, for health maintenance organizations. Otherwise, any mandated increase in private coverage — "presumably financed by premiums" — should be considered in terms of a "minimal target package stripped of preventive care," the paper added.

The CEA paper also insists on stronger cost controls through regulatory legislation, but apart from any expensive health care package. "If the politics of the situation make it possible to combine a comprehensive benefit package with strong cost control, they should also make it possible to get the same cost control without the comprehensive package . . . insurance companies and individuals, who are the beneficiaries of a larger package, are not the ones who object to cost control," the paper concluded.

Enactment of a national health insurance (NHI) program with first rate mental health benefits may be the best, single step to help mentally ill Americans, according to the report of the President's Commission on Mental Health.

Declaring that one out of every seven suffers from some mental affliction, the Commission reported that too many of these are untreated. Almost half of the population could be classed as mentally ill or as experiencing severe emotional problems, the report said.

The Commission, headed by Thomas Bryant, M.D., was formed more than a year ago as a response to the keen interest in mental health by Mrs. Rosalyn Carter and special White House Health Assistant, Peter Bourne, M.D., a psychiatrist.

"We firmly believe that a national health insurance program which includes appropriate coverage for mental health care offers the most effective means of providing adequate financing for . . . all Americans," the 20-member panel reported.

\* \* \*

A "middle-of-the-road" national health insurance bill with powerful Senate backing has been introduced into the Congress. Emphasis in the bill is placed on catastrophic coverage.

The measure is supported by Chairman Russell Long (D-La.) of the Senate Finance Committee, Health Subcommittee Chairman Herman Talmadge (D-Ga.) and Sens. Abraham Ribicoff (D-Conn.) and Robert Dole (R-Kan).

The bill is substantially the same as the one introduced in the 94th Congress by Long.

"Our purpose . . . is to have before the Congress and the American people a legitimate national health insurance approach developed by the Congress," Long told the Senate. "This is not the Administration's proposal, nor that of any special interest group. It is our legislation."

\* \* \*

In an unprecedented joint effort, Senator Edward Kennedy (D-Mass.) and the AMA will sponsor a two and a half day conference on "Positive Health Strategies" in Washington, D.C., July 25-27.

The sponsors have announced plans to bring together interested groups as co-sponsors and participants to focus public attention on the potential benefits of strategies of *disease prevention* and to project possible programs for improvement in the 1980s.

The preliminary program lists keynote speakers as Senator Kennedy, Tom E. Nesbitt, M.D., President-Elect of the AMA, George Meany, President, AFL-CIO, and Lester Breslow, M.D., Dean, School of Public Health, University of California, Los Angeles.

In an address before the AMA's Leadership Conference in January of this year, Senator Kennedy issued an invitation to the AMA to join him in sponsoring a national disease prevention conference designed to focus the attention of the nation on the great potential of preventive measures to reduce the toll of disease in our population.

Dr. Nesbitt, in accepting for the AMA, stated, "we are happy to participate in an arena that encourages a wide spectrum of ideas and programs on health. Organized medicine and physicians have long been concerned with and active in the areas of disease prevention and positive health programs. We are certain that this interaction will be profitable to all Americans."

Meanwhile, Sen. Kennedy has launched a major new health initiative with introduction of legislation to instruct Americans on good health practices and disease prevention.

National health insurance can improve access to care, but it can't "make us a healthier and more long-lived people unless it is combined with a comprehensive strategy for reducing death and disability through prevention," Kennedy told the Senate.

The bill calls for spending of \$150 million the first year climbing to \$300 million. Existing health promotional activities would be expanded at the federal, state and local level and new ones installed.

Lowell Steen, M.D., a member of the AMA Board of Trustees, said the AMA is "basically supportive" of the measure, formally called the National Disease

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Prevention and Health Promotion Act of 1978. Dr. Steen told a national television audience that some of the programs are "things that the AMA has been advocating for many years." However, we have "some reservations" about certain provisions, Dr. Steen said.

Sen. Kennedy, appearing on the same program, said "I think we've got a good partnership," noting the jointly sponsored conference with the AMA in late July.

\* \* \*

The White House Council on Wage and Price Stability plans an educational program for physicians on inflation in health care costs. The Council also will seek the assistance of the AMA in developing an effective monitoring or reporting mechanism to measure the rate of physicians' fees with respect to an agreed upon "measuring device or indicator."

The objective is to develop a long-term mechanism to assist in cutting the rate of increase in the future.

The plans were discussed with AMA officials at a recent Washington, D.C., meeting. Among those attending were John Budd, M.D., AMA President; Frank Jirka, M.D., Vice Chairman of the AMA Board of Trustees; and Bernard Harrison, AMA Group Vice President.

The sweeping drug bill before Congress signals shift in philosophy "where government takes it upon itself to 'protect' patients from their physicians," the AMA has told the Senate Human Resources Subcommittee on Health.

The current philosophy is that of a "joint effort of government and the medical profession to protect unsuspecting patients from unethical manufacturers and vendors," testified Lowell H. Steen, M.D., a member of the AMA Board of Trustees.

The Subcommittee, headed by Sen. Edward Kennedy held four days of hearings on various provisions of the Administration's ambitious proposal to revamp the drug laws.

Dr. Steen said the provisions aimed at "protecting" patients "would unjustifiably interfere with the practice of medicine by placing the Food and Drug Administration between the physician and the patient through the imposition of national standards and criteria for use of drugs."

The bill gives the FDA power in determining safety of a drug, and its abuse potential, whether the drug is being used for non-approved uses, whether FDA believes there is a more appropriate drug or treatment, and whether the drug would have an adverse effect upon public health, the AMA witness noted.

Dr. Steen said "risk of side effects, dependency and



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ther issues of concern are weighed by the physician, using his clinical judgment and knowledge of the patient. It would not be in the interest of providing the best care for patients to reduce the practice of medicine to that of merely following a government issued bookbook or instruction manual on medical practice and treatment modes."

"In the real world of actual practice, physician use of drugs is best controlled, not by the FDA, but by appropriate peer review, continuing medical education and the physician's training and experience, together with his desire to do what is best for his or her patient," said Dr. Steen.

\* \* \*

The Administration's \$500 million Health Maintenance Organization (HMO) bill ran into opposition from key Senators alarmed over reports of widespread fraud and abuse.

"Wouldn't it be best to put brakes on the whole HMO program?" asked Sen. Herman Talmadge (D-Ga.), Chairman of the Senate Finance Subcommittee on Health. Sen. Sam Nunn (D-Ga.), Vice Chairman of the Senate Permanent Subcommittee on Investigations, agreed. Sen. Carl Curtis (R-Nebr.) said that if HMOs are "any good, they will grow on their own" without the need for any federal subsidy.

Nunn told the Finance Subcommittee that "unless remedial action is taken, the federal government, through its program of financing the development of HMOs, faces the prospect of encountering nationwide the same kinds of scandal and abuse that have plagued the California Medicaid program." There is evidence that organized crime is moving into the HMO field, Nunn warned.

The Investigations Subcommittee recently released a report charging large scale abuse and fraud in the California HMO program.

## In Memoriam

### ED BEDDINGFIELD, M.D.

Ed Beddingfield — you will agree — was an uncommon man — delightfully uncommon! Though born and christened Edgar Theodore Beddingfield, I never once heard him called more than Ed Beddingfield — usually just Ed. Everyone knew who you meant. The record of his accomplishments in a short and shortened life would fill a book. And I sincerely hope they will — soon. I believe that every one of us here is at least aware of his participation and leadership in family and industrial medicine, the work of organized medicine, legislative and political activity, community responsibilities, religious involvement, and his special efforts on behalf of the poor, the mentally-ill, the deaf, highway safety, and the medically underserved rural populations. From such a variety of engrossing and altruistic activities, all of which seemed to bring him satisfaction and frequently pleasure, is it possible to select one area of activity that was most meaningful to him, and in which he attained his greatest successes?

Clearly, in my view, Ed Beddingfield loved legislative and political activity more than anything he encountered on this earth, with the exception of his family and his profession.

How successful was he in these specific arenas? For 16 years Ed was a member of the Committee on Legislation of the North Carolina Medical Society,

and for several of these years he served as chairman. During this period Ed routinely spent one day a week (his day off) in Raleigh with the General Assembly whenever it was in session, and many additional days and weeks with legislators. As a result, he earned the friendship, respect and admiration of the members of the assembly and this resulted in a period of unusually good medical legislation — to the lasting benefit of the people of North Carolina.

Ed Beddingfield early in his career realized that medicine cannot survive and continue its mission in our current society without active participation in the political process at all levels and at all times. He was among the original founders of our MEDPAC and he remained a director and truly the guiding light of MEDPAC for the remainder of his life. In addition, Ed served as a director of AMPAC from 1973 and was extremely influential in national and crucial key state elections — as a member of their small candidate support committee.

In 1970, upon the completion of his tenure as president of the North Carolina Medical Society, Ed was appointed to the prestigious council on legislation of the American Medical Association. He served continually and with great distinction on this council until his death and was its chairman in 1976 and 1977. It was in this capacity that he reached the fullest realization of his abilities, attained the zenith of his career and became truly one of the most articulate, convincing,



and effective spokesmen for American medicine in recent history.

A measure of his national stature was his election to the Institute of Medicine of the National Academy of Sciences, a recognition enjoyed by few practicing physicians. Dr. Beddingfield was appointed by President Carter to the Health, Education and Welfare Advisory Committee on National Health Insurance, the only practicing physician so selected. His value and our great loss are emphasized by public statements made at the time of his death. The chief executive officer of the AMA, Dr. Jim Sammons, commented: "His death is a very great loss, not only to medicine but to the public, because of his tremendous knowledge of health care delivery and his rapport with the Congress." The AMA board chairman, Dr. Robert Hunter, said, "He was a beloved person and will be missed both at home and throughout the country. There is no way in the world to replace him." Gov. Jim Hunt called him "one of the greatest public and medical leaders in the history of North Carolina. If ever there was a man who literally gave his life in service to mankind, it was Ed Beddingfield. North Carolina is a far better state because of his life." Even Sen. Edward Kennedy was complimentary: "Although Dr. Beddingfield and I did not often agree, and, in fact, often disagreed, he was well-respected for the testimony he presented and for his forthright views."

What manner of man was this great one among us, who accomplished so much and served so well? What can we learn from his life and character that will enable us to better carry on the work of medicine, as he would insist we do? I have given these questions a great deal of thought.

First, Ed Beddingfield had a keen and perceptive mind. He was a prodigious worker who prepared himself well with long hours of study and thought to support his opinions. His photographic memory allowed him to recall minute details without obscuring the main issues. Most often, he was the best-informed person in a discussion and everyone in the room soon realized this.

Ed had a manner of presentation which, though incisive, was never abrasive. His warm personality, his humility, his sense of fairness required even his opponents to respect him. I have often heard him explain in great detail both sides of an issue on which he had a strong opinion so that his listeners could make their own best judgment, rather than being unduly influenced by his opinion alone. With assured humility, Ed had confidence in his own judgments and appeared never to take disagreements personally. One of his favorite expressions was, "I don't care what you say about me, just so you spell my name right."

Ed had a quick wit and a fine sense of humor, which he used to advantage. I shall never forget the heated debate just last year on the floor of the House of Delegates of the AMA. Ed's, and the Council on Legislation's, position on national health insurance was under widespread attack with the repeated assertions that the grassroots doctors would not accept the

"establishment's" position on national health insurance. Ed finally and calmly rose, reminded the house that "you can't get any more grassroots than Stantonburg, N.C." He said, "Some of you describe our bill and think that we are to the right of Barry Goldwater. Others of you discuss the same bill and describe us as being on the outskirts of Moscow. Catching flak from both the right and the left, we must assume we are right on target." He sat down and the house voted 4-1 to sustain his position.

Many of you know of Ed's pioneering and enduring work with highway safety. He loved the story of the motorcyclist — just after the law had been changed to require helmets — who was stopped by a patrolman for wearing his helmet on his knee. The patrolman insisted that he put the helmet on his head; the cyclist argued that the law only required that he wear the helmet not where he wore it. The cop persisted and finally the driver in disgust put the helmet on his head and drove off. About a mile down the road he had a wreck — and fractured his knee!

Ed's complete honesty showed through his dedication, his faith, his humility and his humor — which was often self-deprecating. He frequently introduced himself as "just a country doctor from Stantonburg" and he would not change his language, his dress, his mannerisms or even his love for malodorous cigars to imply that he was something else. He had a gift for understanding people and why they thought and acted as they did, and he was enormously tolerant of their right to do so as long as the individual was genuine.

In his legislative and political works, Ed always remained the physician and liberally used stories and examples from his own practice and experiences to make his point. He was a physician who could speak the language of laymen. And they understood and believed him. He felt strongly that we in medicine, when involved in legislative and political acts, should stick to medical issues, that our expertise and value are to provide information and guidance on medical matters, and that we lose our credibility if we become involved in other issues.

Ed Beddingfield was convinced that "politics is truly the art of compromise." He lived and worked by that principle and honored it. On occasion, I have heard him criticized for what was misinterpreted as acquiescence on an issue rather than, in fact, the seeking of a higher goal. Our friend, who fits so well the man of Kipling who "could walk with kings nor lose the common touch," lived a full and productive life, of which we and literally thousands of others are the benefactors. I have the warm and pleasant feeling that somewhere tonight Ed Beddingfield, having reached his highest goal, reaffirms his faith in the political process, and would remind us that if we are to succeed — if we are to reach our high and finally our highest objective — we must be willing to compromise, even to finally compromising this earthly life.

N.C. MEDICAL SOCIETY

Presented by James E. Davis, M.D., at the North Carolina MED-PAC Banquet, Pinehurst, North Carolina, May 5, 1978.

### **RICHARD BENJAMIN BOREN, M.D.**

Dr. Richard Benjamin Boren died April 10, 1978. He was born May 22, 1929, at Greensboro. He received his B.S. Degree at the University of North Carolina at Chapel Hill and his M.D. Degree at Duke University. After graduation from medical school, he studied pediatrics in London. He interned at the Medical College of Virginia in Richmond. Dr. Boren served with the U.S. Air Force in Rapid City, S.D., after which he entered the general practice of medicine in Elkin. After serving seven years as a general physician, Dr. Boren returned to Duke University where he completed his psychiatric residency, which included a year of special training in neuropsychiatry at the National Hospital in Queen's Square, London.

Dr. Boren entered the private practice of psychiatry in Winston-Salem in 1966 and was a member of the medical staff of Forsyth Memorial Hospital and held the academic rank of clinical assistant professor in psychiatry at the Bowman Gray School of Medicine. In 1972, Dr. Boren founded Mandala Center, a private psychiatric hospital and clinic where he served as psychiatrist-in-chief.

He was a member of the Forsyth County Medical Society, the North Carolina Medical Society, the American Medical Association and the American Psychiatric Association and was a diplomate of the American Board of Psychiatry and Neurology. He was a member of the Twin City Club of Winston-Salem and the Forsyth Country Club.

Dr. Boren is survived by a daughter, Carol Boren of Chapel Hill; three sons, Richard Boren of Swannanoa, and David and Robert Boren of Elkin; a sister, Mar-

garet Keyes of Greensboro; and his mother, Mrs. R. B. Boren of Greensboro.

Dr. Boren was an industrious, able and dedicated physician whose creativity and love of hard work were exceeded only by his perseverance and zeal in the development and founding of Mandala Center, which stands as his contribution to the medical community and a personal memorial to this outstanding physician.

**FORSYTH COUNTY MEDICAL SOCIETY**

### **WILLIAM NICHOLAS FORTESCUE, M.D.**

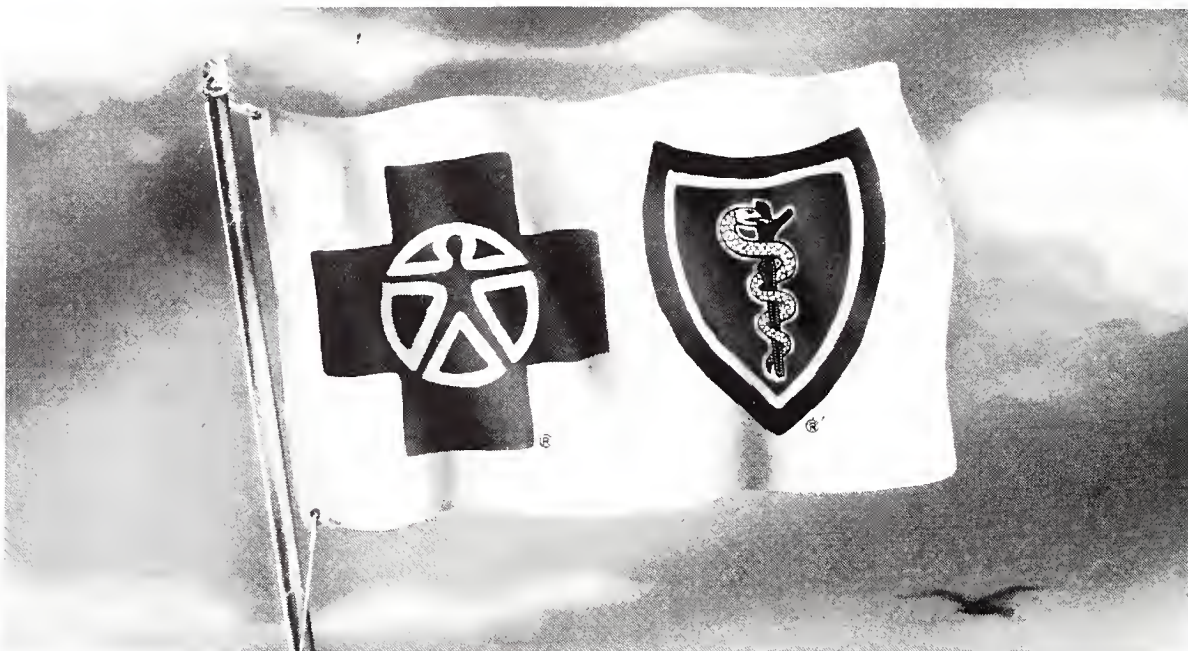
On February 15, 1978, Dr. William Nicholas Fortescue died after an illness of several months.

He lived and practiced medicine in Hendersonville for more than four decades and, in doing so, achieved such works that he will be difficult to replace. His relationship with his colleagues was one of empathy for the young physician, support for the contemporary physician, respect for the elder physicians, and an ever willingness to offer aid and counsel to all those who asked it of him. It is recognized by all that it was he, more than any other one person, who provided the impetus for the initial drive to build the Margaret R. Pardee Memorial Hospital, that during, and after, the construction of this hospital he continued to work endlessly in many ways for future additions to the facility and for the improvement of patient care, and especially for the establishment of a competent clinical laboratory service.

Those who knew him best recognize that he did this work unselfishly and with no thought of personal gain but for the medical community which he loved and which in return loved him.

**HENDERSON COUNTY MEDICAL SOCIETY**





## Here's a North Carolina resource you can depend on.

Name a more valuable asset than the health of the people.

We can't.

And we've spent over 40 years paying this state's health bills. Keeping up with the progress of medicine and helping to make its many benefits available to our subscribers.

It's the reason we have 25 Blue Cross and Blue Shield offices across the state. To cover the health care needs of the more than 2 million people we serve. To stay constantly in touch with the 302 hospitals, nursing homes, home health agencies and 5,355 doctors our subscribers depend on.

It's the reason we publish and distribute thousands of booklets on diet and exercise, immunization, alcoholism, stress and other health subjects. To encourage North Carolina people to take better care of their health.

In these and many other ways your Blue Cross and Blue Shield Plan is constantly working to protect your health. When you're in the health business you have to be ahead of the times just to keep up.

Your Blue Cross and Blue Shield Plan. A North Carolina resource you can depend on.



**Blue Cross  
Blue Shield**  
of North Carolina

***Committee and  
Commission Appointments  
1978-1979***



# Committee and Commission Appointments 1978-1979

NOTE: The Committees listed herein have been authorized by President D. E. Ward, Jr., M.D. and/or as required under the *Constitution and Bylaws*.

Particular note should be taken of the authorization of the HOUSE OF DELEGATES of a Commission form of organization activity and that all Committees, excepting COMMITTEE ON NOMINATIONS and MEDIATION COMMITTEE are segregated under their respective Commission in which the function of the Committee logically rests. This will tend to eliminate overlapping and duplication activity programs and result in coordination of the work of the Society in a manner to lessen the work of the delegates in the Annual Meeting of the HOUSE OF DELEGATES.

(Superior figures (e.g. 21) indicate the component County Society from which the member emanates, as in the Membership list of the ROSTER.)

## I. ADMINISTRATION COMMISSION

T. Tilghman Herring, M.D., *Chairman*  
Wilson Clinic, Wilson 27893

### Committee Listing

1. **Finance, Committee on (I-1)** No. 20  
T. Tilghman Herring, M.D., *Chairman*  
Wilson Clinic, Wilson 27893
2. **Personnel & Headquarters Operation, Com. on (I-2)** No. 38  
A. Hewitt Rose, Jr., M.D., *Chairman*  
3801 Computer Drive, Raleigh 27609
3. **Professional Insurance, Com. on (I-3)** No. 42  
John C. Burwell, Jr., M.D., *Chairman*  
1026 Prof. Village, Greensboro 27401
4. **Retirement Savings Plan Committee (I-4)** No. 44  
Robert W. Williams, M.D., *Chairman*  
3208 Oleander Drive, Wilmington 28401

## II. ADVISORY AND STUDY COMMISSION

T. Reginald Harris, M.D., *Chairman*  
808 Schenck St., Shelby 28150

1. **Allied Health Professionals, Com. on (II-1)** No. 1  
Frank M. Mauney, Jr., M.D., *Chairman*  
275 McDowell Street, Asheville 28803
2. **Anesthesia Study, Com. on (II-2)** No. 2  
Albert Arthur Bechtoldt, Jr., M.D., *Chairman*  
UNC School of Medicine, Chapel Hill 27514
3. **Auxiliary, Committee Advisory to (II-3)** No. 5  
Rose Pully, M.D., *Chairman*  
318 College Street, Kinston 28501
4. **Cancer, Committee on (II-4)** No. 7  
Margaret Ann Nelsen, M.D., *Chairman*  
UNC Dept. of Surgery, Chapel Hill 27514
5. **Constitution & Bylaws, Com. on (II-5)** No. 12  
P. G. Fox, Jr., M.D., *Chairman*  
P.O. Box 17908, Raleigh 27609
6. **Medical Cost Containment, Com. on (II-6)** No. 30  
Jesse H. Meredith, M.D., *Chairman*  
Bowman Gray, Dept. Surg., Winston-Salem 27103

7. **Medical Students, Com. Adv. to (II-7)** No. 3  
James A. Bryan, M.D., *Chairman*  
N.C. Memorial Hospital, Chapel Hill 27514

8. **Traffic Safety, Com. on (II-8)** No. 4  
George Johnson, Jr., M.D., *Chairman*  
N.C. Memorial Hospital, Chapel Hill 27514

## III. ANNUAL CONVENTION COMMISSION

Josephine E. Newell, M.D., *Chairman*  
P.O. Box 68, Bailey 27807

1. **Arrangements, Committee on (III-1)** No. 3  
Jack Hughes, M.D., *Chairman*  
923 Broad Street, Durham 27705
2. **Audio-Visual Programs, Com. on (III-2)** No. 4  
James H. Askins, M.D., *Chairman*  
1665 Owen Dr., Fayetteville 28304
3. **Credentials, Com. on (of House of Delegates) (III-3)** No. 14  
John A. Payne, III, M.D., *Chairman*  
Box 157, Sunbury 27979
4. **Exhibits, Committee on (III-4)** No. 18  
Josephine E. Newell, M.D., *Chairman*  
Box 68, Bailey 27807
5. **Medical Education, Committee on (III-5)** No. 31  
John D. Bridgers, Sr., M.D., *Chairman*  
624 Quaker Lane, High Point 27262

## IV. PROFESSIONAL SERVICE COMMISSION

M. Frank Sohmer, Jr., M.D., *Chairman*  
2240 Cloverdale Ave., Ste. 88, Winston-Salem 27103

1. **Blue Shield, Committee on (IV-1)** No. 6  
John W. Foust, M.D., *Chairman*  
3535 Randolph Road, Charlotte 28222
2. **Crippled Children's Program, Adv. Com. to (IV-2)** No. 15  
Ralph W. Coonrad, M.D., *Chairman*  
1828 Hillandale Road, Durham 27705
3. **Health Planning & Development, Com. on (IV-3)** No. 21  
Henry H. Nicholson, Jr., M.D., *Chairman*  
1012 Kings Drive, Ste. 708, Charlotte 28283

- |  |               |   |               |
|--|---------------|---|---------------|
| <b>Hospital &amp; Professional Relations, Com. on (IV-4)</b>                                 | <b>No. 22</b> | <b>2. Chronic Illness, TB &amp; Heart Disease, Com. on (VI-2)</b>   | <b>No. 9</b>  |
| W. W. Fore, M.D., <i>Chairman</i><br>1705 W. 6th Street, Greenville 27834                    |               | J. Dewey Dorsett, Jr., M.D., <i>Chairman</i><br>1851 E. 3rd Street, Charlotte 28204                         |               |
| <b>Industrial Commission, Com. to Work with N.C. (IV-5)</b>                                  | <b>No. 23</b> | <b>3. Drug Abuse, Committee on (VI-3)</b>   | <b>No. 17</b> |
| Ernest B. Spangler, M.D., <i>Chairman</i><br>Drawer X3, Greensboro 27402                     |               | John A. Ewing, M.D., <i>Chairman</i><br>N.C. Memorial Hospital, Chapel Hill 27514                           |               |
| <b>Insurance Industry Committee (IV-6)</b>   | <b>No. 24</b> | <b>4. Marriage Counseling &amp; Family Life Education, Com. on (VI-4)</b>                                   | <b>No. 26</b> |
| Charles H. Duckett, M.D., <i>Chairman</i><br>Bowman Gray, Winston-Salem 27103                |               | Marianne S. Breslin, M.D., <i>Chairman</i><br>Duke University Med. Ctr., Box 3837, Durham 27710             |               |
| <b>Rehabilitation Medicine, Com. on (IV-7)</b>   | <b>No. 43</b> | <b>5. Maternal Health, Committee on (VI-5)</b>  | <b>No. 27</b> |
| Edwin H. Martinat, M.D., <i>Chairman</i><br>3333 Silas Creek Parkway, Winston-Salem 27103    |               | W. Joseph May, M.D., <i>Chairman</i><br>300 S. Hawthorne Road, Winston-Salem 27103                          |               |
| <b>Social Services Programs, Com. on (Including Medicaid) (IV-8)</b>                         | <b>No. 45</b> | <b>6. Mental Health, Committee on (VI-6)</b>  | <b>No. 34</b> |
| E. Stephen Edwards, M.D., <i>Chairman</i><br>1300 St. Mary's Street, Raleigh 27605           |               | Philip G. Nelson, M.D., <i>Chairman</i><br>Medical Pavilion, Ste 9, Greenville 27834                        |               |
| <b>V. PUBLIC RELATIONS COMMISSION</b>  |               |   |               |
| Marshall S. Redding, M.D., <i>Chairman</i><br>708 W. Church Street, Elizabeth City 27909     |               |   |               |
| <b>Communications, Com. on (V-1)</b>   | <b>No. 10</b> | <b>7. Occupational &amp; Environmental Health, Com. on (VI-7)</b>   | <b>No. 37</b> |
| John L. McCain, M.D., <i>Chairman</i><br>Wilson Clinic, Wilson 27893                         |               | Charles G. Gunn, Jr., M.D., <i>Chairman</i><br>Hanes Corp., Box 5416, Winston-Salem 27103                   |               |
| <b>Community Medical Care, Com. on (V-2)</b>   | <b>No. 11</b> | <b>8. Physician's Health &amp; Effectiveness, Com. on (VI-8)</b>  | <b>No. 40</b> |
| Ronald H. Levine, M.D., <i>Chairman</i><br>2404 White Oak Road, Raleigh 27609                |               | Theodore R. Clark, M.D., <i>Chairman</i><br>P.O. Box 711, Pinehurst 28374                                   |               |
| <b>Disaster &amp; Emergency Medical Care, Com. on (V-3)</b>                                  | <b>No. 16</b> | <b>Committees Not Assigned to a Commission</b>  |               |
| George Johnson, Jr., M.D., <i>Chairman</i><br>N.C. Memorial Hospital, Chapel Hill 27514      |               | <b>COUNCIL ON REVIEW &amp; DEVELOPMENT</b>  |               |
| <b>Eye Care &amp; Eye Bank, Com. on (V-4)</b>  | <b>No. 19</b> | Jesse Caldwell, Jr., M.D., <i>Chairman</i><br>113 W. Third Ave., Gastonia 28052                             |               |
| Albin W. Johnson, M.D., <i>Chairman</i><br>1300 St. Mary's Street, Raleigh 27605             |               | <b>MEDIATION COMMITTEE</b>  |               |
| <b>Legislation, Committee on (V-5)</b>   | <b>No. 25</b> | George G. Gilbert, M.D., <i>Chairman</i><br>1 Doctors Park, Asheville 28801                                 |               |
| John T. Dees, M.D., <sup>65</sup> <i>Chairman</i><br>P.O. Box 815, Burgaw 28425              |               | E. Harvey Estes, Jr., M.D., <i>Secretary</i><br>Duke Univ. Med. Ctr., Box 2914, Durham 27710                |               |
| <b>Medical Aspects of Sports, Com. on (V-6)</b>  | <b>No. 29</b> | <b>COMMITTEE ON NOMINATIONS</b>   |               |
| Frank W. Clippinger, Jr., M.D., <i>Chairman</i><br>Duke Medical Ctr., Box 3935, Durham 27710 |               | Leon W. Robertson, M.D., <i>Chairman</i><br>107 Med. Arts Mall, Rocky Mount 27801                           |               |
| <b>Medical-Legal Committee (V-7)</b>   | <b>No. 32</b> | <b>1. Committee on Allied Health Professionals (7) (3 Consultants) II-I</b>                                 |               |
| Julius Howell, M.D., <i>Chairman</i><br>Bowman Gray, Winston-Salem 27103                     |               | Frank M. Mauney, Jr., M.D. <sup>11</sup> <i>Chairman</i><br>275 McDowell Street, Asheville 28803            |               |
| <b>Pharmacy, Committee on (V-8)</b>  | <b>No. 39</b> | William R. Bullock, M.D. <sup>70</sup><br>217 Travis Avenue, Charlotte 28204                                |               |
| Charles W. Byrd, M.D., <i>Chairman</i><br>Box 708, Dunn 28334                                |               | Walter L. Holton, M.D. <sup>70</sup><br>Box 1045, Manteo 27954  |               |
| <b>VI. PUBLIC SERVICE COMMISSION</b>   |               | Joyce H. Reynolds, M.D. <sup>34</sup><br>9550 Freeman Road, Kernersville 27284                              |               |
| Philip G. Nelson, M.D., <i>Chairman</i><br>Medical Pavilion, Ste. 9, Greenville 27834        |               | Wayne B. Venters, M.D. <sup>67</sup><br>200 Doctors Drive, Ste. J, Jacksonville 28540                       |               |
| <b>Child Health &amp; Infectious Diseases, Com. on (VI-I)</b>                                | <b>No. 8</b>  | Michael D. Weaver, M.D. <sup>74</sup><br>1711 W. Sixth Street, Greenville 27834                             |               |
| William L. London, M.D., <i>Chairman</i><br>306 S. Gregson Street, Durham 27701              |               | Thad B. Wester, M.D. <sup>78</sup><br>103 W. 27th Street, Lumberton 28358                                   |               |
|  |               | <b>Consultants:</b>   |               |
|  |               | Ms. Allene Cooley, Nurse Practitioner<br>Physician's Associate Program,<br>Bowman Gray, Winston-Salem 27103 |               |



Bryant D. Paris, Jr., Executive Secretary  
N.C. Board of Medical Examiners,  
Suite 214, 222 N. Person Street, Raleigh 27601  
Paul Toth, P.A., President  
P.A. Association, Dept. of Surgery,  
Duke Univ. Med. Ctr., Durham 27710

## 2. Committee on Anesthesia Study (11) II-2

Albert Arthur Bechtoldt, Jr., M.D.<sup>32</sup> *Chairman*  
UNC School of Medicine, Dept. Anes., Chapel Hill 27514  
Benjamin F. Fortune, M.D.<sup>41</sup>  
906 Cornwallis Drive, Greensboro 27408  
Lewis J. Gaskin, M.D.<sup>92</sup>  
Rex Hospital, Dept. Anes., Raleigh 27603  
Merel H. Harmel, M.D.<sup>32</sup>  
Duke Univ. Med. Ctr., Box 3094, Durham 27710  
Charles T. Harris, Jr., M.D.<sup>60</sup>  
401 Fesbrook Court, Charlotte 28211  
Glen E. Hawkins, M.D.<sup>53</sup>  
106 Hillcrest St., Sanford 27330  
John R. Hoskins, III, M.D.<sup>11</sup>  
202 Doctors Bldg., Asheville 28801  
Stephen H. Mazur, M.D.<sup>96</sup>  
504 Walnut Creek Drive, Goldsboro 27530  
Rodney L. McKnight, M.D.<sup>23</sup>  
Box 957, Shelby 28150  
Bill Joe Swan, M.D.<sup>13</sup>  
776 Williamsburg Dr., Concord 28025  
H. Ryland Vest, Jr., M.D.<sup>76</sup>  
529 Edgewood Road, Asheboro 27203

## 3. Committee on Arrangements (9) III-1

Jack Hughes, M.D.<sup>32</sup> *Chairman*  
923 Broad Street, Durham 27705  
Mrs. A. J. Crutchfield (Auxiliary)  
Quail Hollow Rd., Box 848, Clemmons 27102  
Charles Davant, III, M.D.<sup>95</sup>  
P.O. Box 8, Blowing Rock 28605  
John Glasson, M.D.<sup>32</sup>  
306 S. Gregson Street, Durham 27701  
Patrick D. Kenan, M.D.<sup>32</sup>  
Duke Med. Ctr., Div. of Otol., Durham 27710  
Marvin N. Lymberis, M.D.<sup>60</sup> (Speaker)  
1600 E. 3rd Street, Charlotte 28204  
Emery C. Miller, Jr., M.D.<sup>34</sup>  
Bowman Gray, Winston-Salem 27103  
Hoke S. Nash, Jr., M.D.<sup>60</sup>  
1600 E. 3rd Street, Charlotte 28204  
William H. Romm, M.D.<sup>70</sup>  
Box 10, Moyock 27958

## 4. Committee on Audio-Visual Programs (6) III-2

James H. Askins, M.D.<sup>26</sup> *Chairman*  
1665 Owen Dr., Fayetteville 28304  
George P. Henderson, Jr., M.D.<sup>63</sup>  
115 Highland Rd., Southern Pines 28387  
Lyndon K. Jordan, M.D.<sup>51</sup>  
Box 760, Smithfield 27577  
Hervy B. Kornegay, Sr., M.D.<sup>96</sup>  
238 Smith Chapel Rd., Mt. Olive 28365  
Carolyn B. McCormick, M.D.<sup>78</sup>  
500 W. 27th St., Lumberton 28358  
Jack P. McDaniel, M.D.<sup>26</sup>  
514 Owen Dr., Fayetteville 28304

## 5. Committee Advisory to Auxiliary (4) (2 Consultants) II-3

Rose Pully, M.D.<sup>54</sup> *Chairman*  
318 College Street, Kinston 28501

Richard E. Frazier, M.D.<sup>42</sup>  
120 Prof. Dr., Roanoke Rapids 27870  
Robert Lee Means, M.D.<sup>34</sup>  
Prof. Bldg., 2240 Cloverdale Ave., Winston-Salem 27103  
Hal J. Rollins, Jr., M.D.<sup>43</sup>  
348 N. Elm Street, Greensboro 27401

## Consultants

Mrs. Paul S. O'Brien (Doris)  
2622 Bucknell Avenue, Charlotte 28207  
Mrs. John C. Reece (Adelaide)  
220 Riverside Dr., Morganton 28655

## 6. Committee on Blue Shield (32) IV-1

John W. Foust, M.D.<sup>60</sup> (OT) *Chairman*  
3535 Randolph Rd., Charlotte 28222  
Walter M. Roufail, Jr., M.D.<sup>34</sup> (GE) *Vice-Chairman*  
2240 Cloverdale Ave., Winston-Salem 27103  
Millard B. Bethel, M.D.<sup>92</sup> (PH)  
25 Banbury Lane, Chapel Hill 27514  
Jack W. Bonner, III, M.D.<sup>11</sup> (P)  
Highland Hosp., Box 1101, Asheville 28802  
Paul L. Burroughs, Jr., M.D.<sup>92</sup> (ORS)  
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**3. Committee on Child Health & Infectious Diseases (12) VI-1**

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**9. Committee on Chronic Illness, Including TB & Heart Disease (14) VI-2**

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**12. Committee on Constitution & Bylaws (5) II-5**

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**13. Council on Review & Development (10) (4 Ex Officio with vote) (1 non-voting)**

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**Ex Officio Non-Voting**

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**14. Committee on Credentials (of Delegates to House of Delegates) (3) III-3**

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#### 19. Committee on Eye Care & Eye Bank (15) V-4

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**27. Committee on Maternal Health (14) (5 Consultants) (6-yr terms) VI-5**

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**29. Committee on Medical Aspects of Sports (16) (2 Consultants) V-6**

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**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication, abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

**Injectable:** To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intrarterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion line as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Seizures as precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less), prolonged CNS depression observed. In children, give slowly (up to 0.25 g/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

**Precautions:** If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function, avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

**Injectable:** Although promptly controlled, seizures may return, readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

**Adverse Reactions:** Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported. Should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

**Injectable:** Venous thrombosis/phlebitis at injection site, hypotension, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

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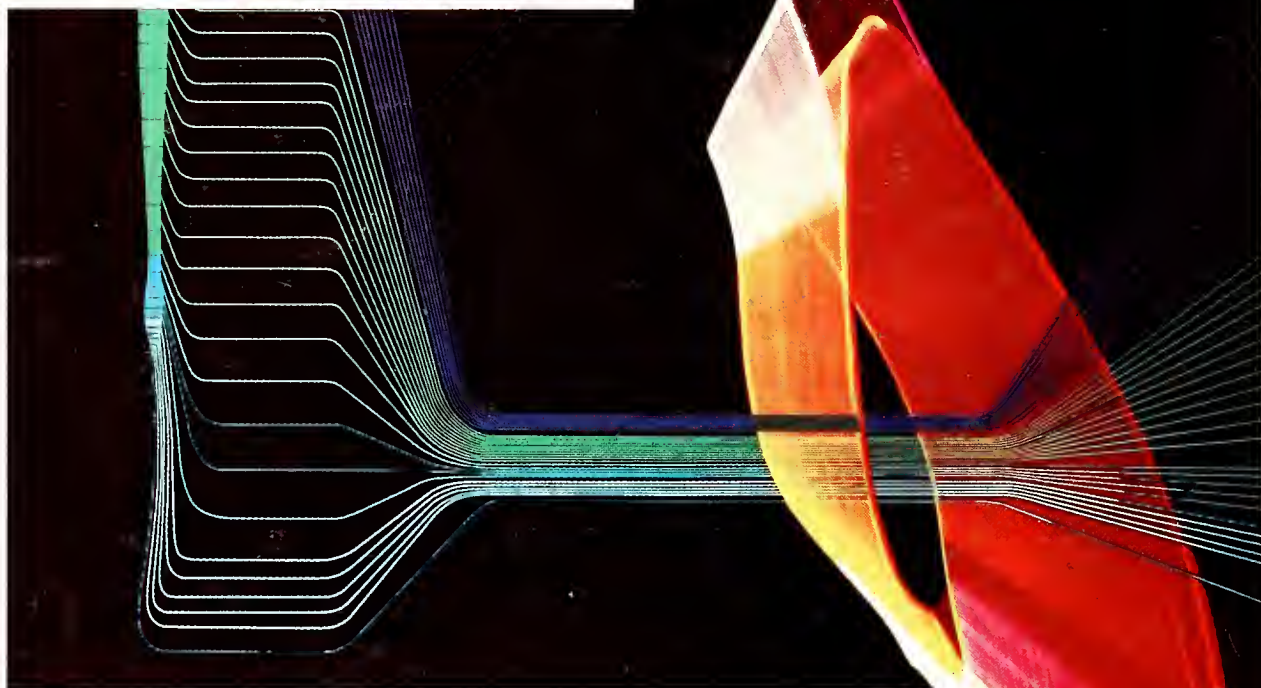


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**SPECIAL ARTICLE:** Dr. Jerome L. Reeves on Death and Dying: An Interview: Hugh A. Matthews, M.D.

**CURRENT THERAPY:** The Use of Heparin and Warfarin as Anticoagulants: John J. Stuart, Ph.D., M.D.

**Thyroid Function Testing:** An Introduction to the Thyrotropin-Releasing Hormone (TRH) Stimulation Test: Denis I. Becker, M.D.

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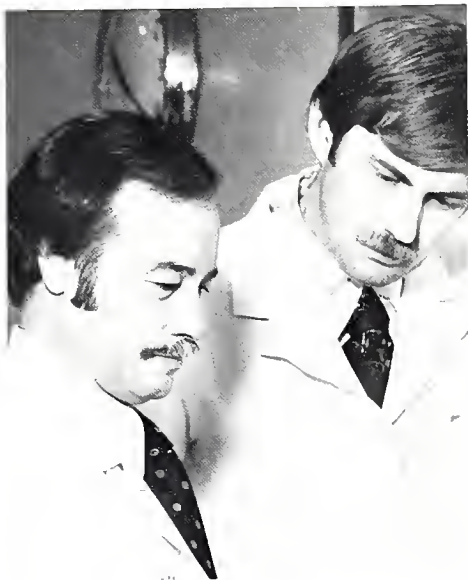
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August 1978, Vol. 39, No. 8

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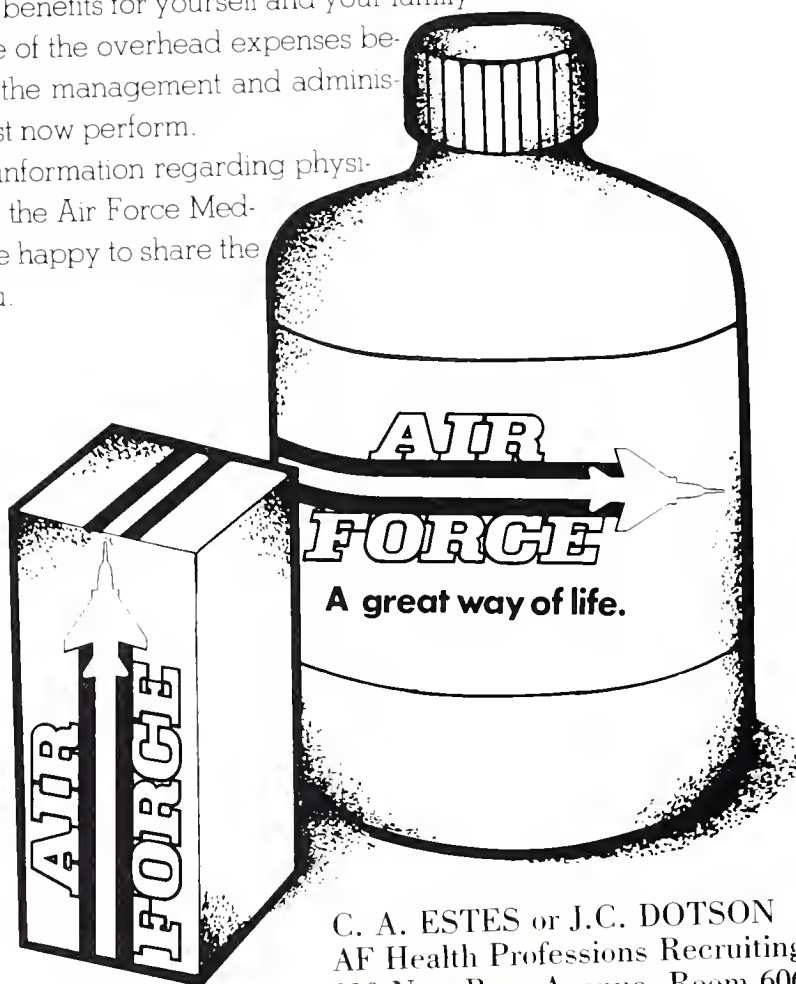
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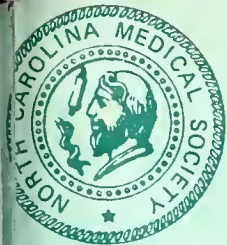
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# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

No. 3

August 1978

The first North Carolina Medical Society "Think Tank" Planning Conference was held in Williamsburg, Virginia, July 27-30, 1978. There were 46 in attendance including physicians, Auxiliary officers, staff, and wives. Many facets of our Society's structure, committees, ideals, future plans, and meetings were discussed.

Items included: Increased participation of Commissioners in the Executive Council, changing the format of our Annual Meeting, separating the Communications and Legislation Committees from their Commission into separate departments, securing staff personnel to work completely in the fields of communications and legislation, plans to delete and combine some of our committees, and increasing specialty section meetings and medical school reunions at the Annual Meeting. We discussed encouraging Councilors to visit each county society meeting in their district and more participation of the Vice-Councilors in District and Council activities. It was recommended that meetings be held for physicians during the coming year to include Legislative Training, AMA Speech Training, and Practice Management Seminars. A Legislative Seminar is planned for 1979 and increased participation of the county medical societies and physicians in the Medical Society Foundation, Inc., was suggested. It was also suggested that resolutions from a county medical society to the House of Delegates be signed by two officers of the county society. You will be hearing about these and many more items at the Committee Conclave at Mid Pines.

I would like to express my deepest appreciation to the following who attended the conference: Drs. J. Dewey Dorsett, Jr., James Greenwood, John Felts, Louis Shaffner, John T. Dees, John S. Rhodes, Bruce B. Blackmon, Ernest B. Spangler, Marshall Redding, Jack Hughes, John Glasson, Frank Sohmer, Jr., Marvin Lymberis, Ben Warren, Josephine Newell, Edward Eadie, Tilghman Herring, Harvey Estes, and Mrs. Ann Frazier, Mrs. Mary Leila Andrews, Mrs. Mary Jane Means, also Mr. William Hilliard, Mr. Gene Sauls, Mrs. LaRue King, and Mr. Bruce Balfe (AMA).

An ad hoc Search Committee for a Legislative Staff Member has been appointed including: Drs. John R. Gamble, Jr., John T. Dees, A. Hewitt Rose, Jr., and E. Harvey Estes, Jr.; Chairman.

Some of the surgeons in our state have received a letter from the Prudential Insurance Company of America inviting them to participate as panelists in Prudential's Elective Surgical Second Opinion Program. The company states as soon as the panels of Board Certified specialists have been established, the program would be offered through the Prudential Group Class in your area. I encourage each of you to read this letter carefully before signing as a panelist for there are definitely several objectional features to this program.

Items from around the state: The Medical Society is proud to have two members on the Federated Council for Internal Medicine, Dr. Reginald Harris representing the ASIM and Dr. Joseph E. Johnson, III, representing the Professors of Medicine. Mrs. Mary Jane Means, Auxiliary President, has been appointed Chairman of a

statewide Committee on Immunization. Mrs. Martha Martinat, Auxiliary Past President, has been appointed on the State Committee on Drug Abuse. AMA-ERF collections for North Carolina through our Auxiliary total \$22,000.

Drs. M. Frank Sohmer, Jr., and J. Benjamin Warren have been appointed to represent the Society on the North Carolina Statewide Professional Standards Review Council. Dr. Theodore R. Clark, Chairman of the Committee on Physicians' Health and Effectiveness, will attend the Third National Conference on the Impaired Physician sponsored by the AMA in Minneapolis, Minnesota. Dr. John T. Dees, Burgaw, N.C., has been appointed Chairman of the Committee on Legislation.

Dr. Philip G. Nelson, Chairman of Committee on Mental Health, has been appointed by the Board of Trustees of AMA to the ad hoc Task Force on Mental Health in order to assist the AMA Jail Project in developing guidelines for jail medical care in the area of mental health. Dr. William L. London, Durham, will serve as the Society's representative on the North Carolina Advisory Committee on Immunization.

The Committee on Medical Aspects of Sports held their annual Sports Symposium at Wrightsville Beach, N.C., on July 4th weekend. They had an excellent program and the largest participation of physicians in any of the previous symposiums.

As a result of the unfortunate death of Archie T. Johnson, Jr., M.D., First Vice-President of the Society, and in keeping with our Bylaws, Albert Stewart, Jr., M.D., of Fayetteville has been elevated from Second to First Vice-President.

Many thanks from the Society to the Honorable James T. Broyhill for his substitute bill in the House Commerce Committee in regard to the Administration's Federal Cost Control Bill. Congressman Broyhill's bill would give our State Voluntary Cost Containment Committee time to function and achieve our two percent reduction for 1978 and 1979.

The North Carolina Voluntary Cost Containment Committee has been appointed by the Medical Society and the North Carolina Hospital Association and will have their first meeting August 22, 1978, in Raleigh. Dr. Jesse Meredith, Winston-Salem, and Dr. John Glasson, Durham, will represent the Society.

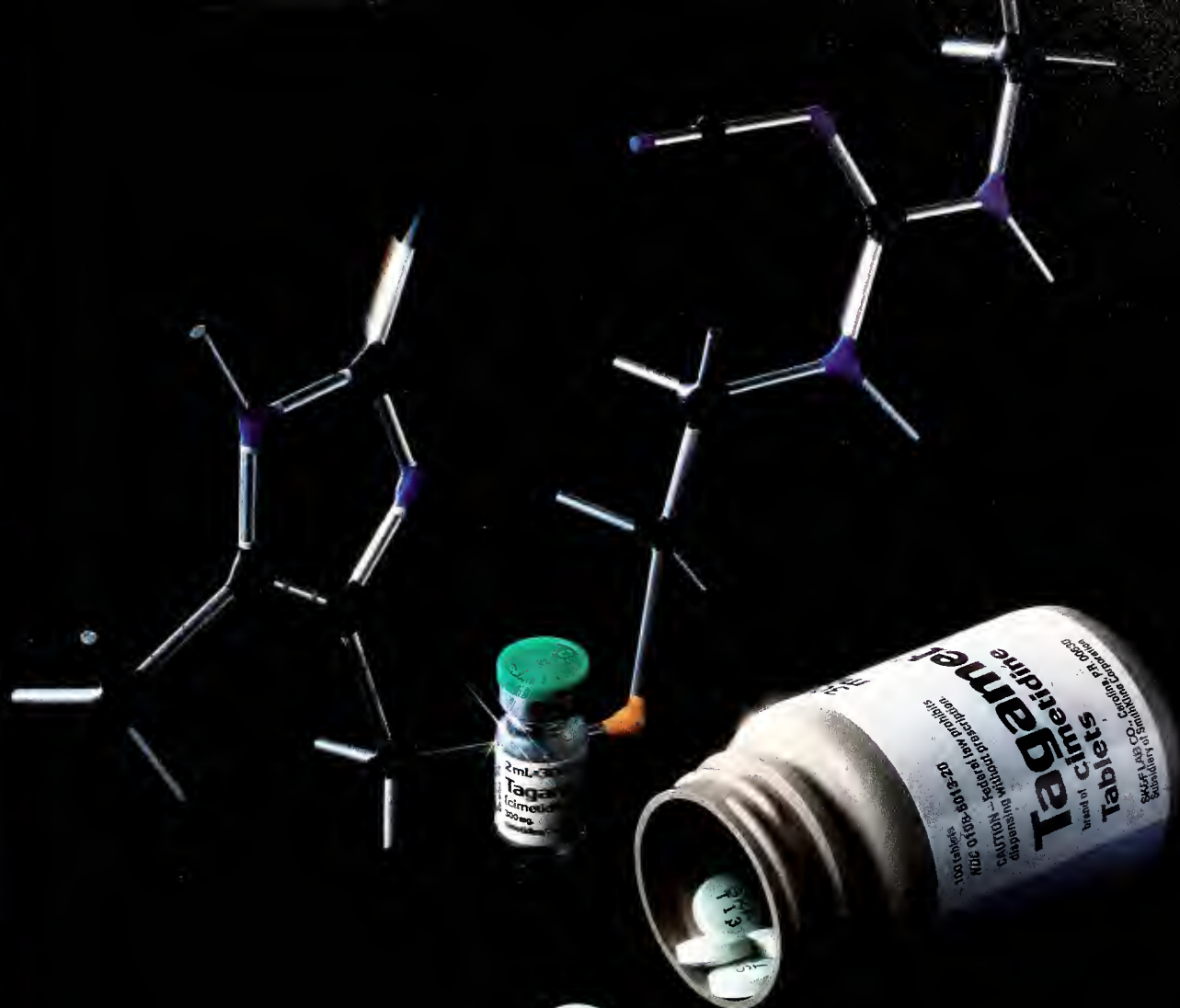
As another benefit of Society membership, an agreement has been negotiated with Avis Rent A Car System to provide a significant discount to all members of the North Carolina Medical Society. Watch for an announcement in the BULLETIN soon for the effective date and for details about the program.

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This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

### Neomycin

*Staphylococcus*  
*Haemophilus*  
*Klebsiella*  
*Aerobacter*  
*Escherichia*  
*Proteus*  
*Corynebacterium*  
*Streptococcus*  
*Pneumococcus*

### Bacitracin

*Staphylococcus*  
*Corynebacterium*  
*Streptococcus*  
*Pneumococcus*

### Polymyxin B

*Pseudomonas*  
*Haemophilus*  
*Klebsiella*  
*Aerobacter*  
*Escherichia*

*In vitro* overlapping antibacterial action of Neosporin<sup>®</sup> Ointment (polymyxin B-bacitracin-neomycin).



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## Neosporin<sup>®</sup> Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



# SPECIAL ARTICLE

## Dr. Jerome L. Reeves on Death and Dying An Interview

Hugh A. Matthews, M.D.

**D**URING the spring of 1913 Dr. Jerome L. Reeves nailed his final, not proverbial, shingle on the one-room office door in the old logstore in the town of Whittier, tucked away in the heart of North Carolina Appalachia. Arriving by train, he brought with him his formal training, mountain heritage, compassion for people, and little else, not even a blood pressure apparatus.

Born in the home of a Little Sandy Mush farmer and lay Methodist preacher in the northern corner of Madison County, the inchoate physician was later moved down to the Leicester community, where public school was available for three months instead of his original one month. After Camp Academy was opened the young man was entered into this subscription school." Upon graduation, he studied at North Carolina A and M (now N.C. State University) in Raleigh where he was named to the Naval Academy at Annapolis. After one year at Wertz Preparatory School in Annapolis, he studied four years at the Naval Academy and then four years at Vanderbilt Medical School, graduating in the class of 1913.

During succeeding years he was recurrently in Chicago and at New York Postgraduate for continued surgical and medical training.

After three years in Whittier, "a more seasoned doctor" moved to Ravenford, a lumber camp setting three miles out from the village of Cherokee. His beat took him into all the counties in southwestern North Carolina now often referred to as the State of Franklin and once a part of the State of Franklanders put down by the North Carolina militia. Like the Franklanders, he traveled mostly by horse and foot. "Without bridges, wheels had a limited use."

With the late Dr. Tidmarsh, Dr. Reeves was co-founder of the old Bryson City Hospital. Dr. Candler later joined the two in beginning the present C. J. Harris Community Hospital in Sylva.

In 1928 Dr. Reeves established his practice in Canton. He was on the medical staff of Haywood County Hospital for 42 years until his reluctant but necessary retirement in 1970 due to the illness of his beautiful wife. Upon his retirement at 83, he was as respected for his decision-making in general as he was for his medical and surgical skills. In his practice expertise as in his enthusiasm for development, he was regarded by his peers as one of the younger men (as all his fellow physicians will attest).

At 90, Dr. Reeves, in his own words, experienced "the event of death" and "continued the life process in another realm of existence." This interview, which took place when Dr. Reeves was 88, was the last conversation between the teacher-physician and his student.

*Dr. Reeves:* Now, what are you going to bull about today?

*Student:* The lively subject of death and dying.

*Dr. Reeves:* The subject may be more lively than you think.

*Student:* I am aware that increasingly the subject has become of more outward concern over the country. Human resource people — social service personnel, psychological therapists, nursing groups, physicians, others — write articles for the journals and hold seminars and workshops on the grief process and related subjects.

*Dr. Reeves:* Yes, I am aware. And nosy doctors come by to talk with me about it. It is perhaps in most part healthy. Fear of death is part of the human condition. In the present day, society needs to talk about death more.

Life has always been uncertain. Now the uncertainty is constantly before the public on TV and radio, the newspapers and magazines. The threat of nuclear war is real and epidemics are presented as if we never had the scourges of smallpox,

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typhus, and others. Before technological advance in information, we didn't know what was going on all over the world.

Then, our systems of belief have been shaken. In general, religious faith is less a tool in managing our fear of death. The Christian faith and other religious faiths hold that when man dies, he continues the life process. A part of the human condition is that we can't conceive of or tolerate the idea of nothingness — of ceasing to be.

I've thought about it. Technology rather than Divine Being has become our god more than we know. Deep underneath, the public has faith that medical technology has control over life and death.

People tend to feel resentful toward the doctor when a patient dies. First, there is disbelief, mental shock in a way, as if the death event in life couldn't happen, as if the death could have been prevented. More and more people who suffer loss feel hostile toward the doctor or hospital and feel guilty that they hadn't done something more or different.

*Student:* Hasn't this always been true?

*Dr. Reeves:* Of course. It's a matter of degree. It certainly was true when I began practice back in the mountains in 1913. All people didn't handle grief well. Almost all did. They accepted death as an event of life more than now — in general, that is. They genuinely felt that the inevitable in some satisfying way was God's will, that loved ones in the truest sense lived on and that only the flesh returned to dust. Death wasn't a finality excepting as an event in a process. . . .

Something else occurs to me. Time was when children were acquainted more with death — not in the general threatening sense as from violence of TV, but in an immediate, at-home loss. Grandparents and infant brothers and sisters died right in the home. In a rural society, children had their own animals which died by violence or disease or by useful slaughter. Birth and death were almost daily immediate events in the homestead. Yes, this must make a difference.

*Student:* What about TV — violence on TV?

*Dr. Reeves:* This must make a difference for good and for bad. A bigger difference is the parents themselves.

A bigger difference than TV is that parents often are not there and perhaps a bigger difference is what they are when they are there.

I think about it. . . . But, I have no satisfactory conclusions. Things as they are, what would children do without TV? Programs might be different, should be different. . . . But, who is to say?

*Student:* You say that persons often react to death first with disbelief or denial, then with some degree of hostile feeling toward others or toward themselves, and perhaps guilt feelings. Then they accept the reality and resolve their feelings of hostility and guilt, or they persist in varying degrees of denial, hostility, and guilt feelings. How can the doctor or others help in resolving the grief process?

*Dr. Reeves:* Well, I didn't say all of that, but you said it pretty well. You got some mighty big words at the university.

I'm no authority, but I guess I have helped most by being there. I could never leave the dying and the dead to the granny woman or the nurse, as important as they are.

The doctor has never done all he can do. There is more to medicine than scalpels and the pills.

We can understand that when the bereaved are refusing to accept a loss they need at the moment to deny it. They deserve understanding at this time and not argument. A touch of the hand is of more worth than a medical lecture at this time.

If the grieved one turns upon us, we can be helpful, even if uncomfortable, in being a punching bag. When we understand the grieved patients need to get it off the chest, we can accept the temporary punching-bag role with less hostility ourselves. Almost all patients who have punched me have been sorry later. We should be there off and on for the puncher to say so and be prepared to accept apology with understanding.

You know, doctors might con-

tribute to the bad responses of patients and their loved ones to death and dying. Doctors and all the medical people can do so much now, so much that we lose sight that we are still creatures and not the Creator.

I am convinced that I have never hurt myself or any who depended upon me in being honest. I have never regretted sharing what I knew and what I didn't know with a patient and the family.

*Student:* I am often asked at non-medical workshops, should the physician tell the patient or the patient's family that a patient has an incurable disease?

*Dr. Reeves:* By golly, be honest! I've been, and you'd better be!

That does not involve being crazy. None of us, dying or not, want to be told something we already know, most particularly something that is unpleasant. And you don't have to be God to be honest.

I have been wrong in my judgments but never sorry in being honest.

It is one thing to say, "You have an incurable cancer." It is another to say, "The best that we know, you have cancer. We will outline a program for you to do all that can be done at the present time."

*Student:* How about old people

*Dr. Reeves:* Be honest! Whichever single old people for dishonesty. The family may pressure you not to tell grandma or grandpa. Grandma and grandpa may already know. . . . not, in my experience, the old people accept bad news better than an other group. Survivors of the fittest; they are more acquainted with grief.

*Student:* You said that perhaps the greatest contribution the physician could make to the dying and the grieved was to be there. In present day delivery of health and medical services to patients, the physician frequently can't "be there" with the family and others who feel loss. For example, the vascular surgeon or surgical team often is one hundred three hundred, a thousand mile away.

*Dr. Reeves:* Yes, that is true and one of the disadvantages of all the advantages in the advances of tech-

ology. Hopefully, the movement will continue so that almost all American citizens will have a family doctor.

Still, the physician isn't and never has been the only person who meets needs of people. By law and by the way things are, the physician is here at some point in death. Since he has the opportunity, he has the obligation to do what he can where he is.

As keen as doctors are, they cannot get the credit for the great advances in preventing death and human suffering. You gave an example. I'll give an example.

Back in the hills before and during World War I, a major killer of infants and little children was intestinal parasites. My pills and potions never changed that. The change came with better nutrition, better hygiene, and a healthier environment. The same is true with typhoid, typhus, malaria, and others.

The mental health workers and social services people and others —

and don't forget ministers — are helping people. It is good that these and others are now concerned with people's needs in the problem area of death and dying.

When the community was more confined and less complicated, perhaps helping people didn't need as much as now to learn in a formal way how to understand and to deal with grief. The workshops and journal articles are good.

Doctors might need to refer grieving people more often to other helpers. We might learn more from them.

*Student:* Dr. Reeves, one more question. How about mercy killing, euthanasia?

*Dr. Reeves:* This was never a personal problem for me and perhaps wouldn't be now. There is a common sense difference in prolonging life and prolonging death. There is a common sense difference in giving life supports and death supports. There is a difference in giving medicine to end life and in withdrawing supports which delay death. When

the treatment program is shared with the family or the most responsible member or members of the family, misunderstanding will rarely or never occur.

*Student:* Yet, misunderstanding does occur and the ethical problem still exists.

*Dr. Reeves:* Well, most real ethical problems are not solved. I'm not talking about whether you dance or don't dance. Real ethical problems have something to do with human dignity, human worth. These problems are eternal and their solution is in a process and not a status.

*Student:* I'll think about that one. I don't wish to tire you out.

*Dr. Reeves:* It's you that's tired.

*Student:* Well, as ever, I do thank you.

*Dr. Reeves:* What for? I enjoyed the visit.

*Student:* I am grateful that you are you and that you have embraced me in all my practice life. You have taught me much.

*Dr. Reeves:* You always could lay it on. I didn't teach you that.

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I fixed a musket Barrel to the pulmonary Vein, near its Entrance into the left Auricle; and tyed the ascending and descending *Aorta's* fast, at some Distance from their branching off from each other. Then placing the Barrel in a perpendicular Posture, with a Funnel on the top of it, I poured in melted Bees-wax, till the Funnel was half filled. Yet as I had found by Experience, this perpendicular Height of melted Wax, which was near four Feet, would not have filled the Auricle and Ventricle, if I had not at the same time taken care to pass a small brass Pipe, thro' one of the ascending Branches of the *Aorta*, into the left Ventricle; thro' which the Air passed off as the Wax entered into the Ventricle, the brass Pipe being at the same time gradually drawn up by an Assistant, who as soon as all the Air was driven out tyed that Branch of the *Aorta* to prevent the flowing out of the Wax. Statical Essays: Containing Haemastaticks by Stephen Hales, London, 1733.

# CURRENT THERAPY

## The Use of Heparin and Warfarin as Anticoagulants

John J. Stuart, Ph.D., M.D.

### HEPARIN

**H**EPARIN is a mucopolysaccharide which is commercially derived from beef lung or pork intestine. There are no differences between bovine and porcine heparin in efficacy or antigenicity. The anticoagulant action of heparin has been shown to be mediated by the plasma protein antithrombin III<sup>1</sup> which will slowly react with and neutralize any activated clotting factors which are free in the circulation. Heparin binds electrostatically to the antithrombin III molecule and speeds as much as a hundred times its rate of reaction with activated clotting factors. In the absence of antithrombin III, heparin has no anticoagulant activity<sup>2</sup> and so might properly be called "antithrombin III cofactor."

#### *Metabolism*

Heparin is extensively bound to fibrinogen and globulins in the blood.<sup>3</sup> Its volume of distribution in therapeutic dosage is confined to the plasma volume. Little is known about the effect of other drugs on its protein binding. At therapeutic dosage the biological half-life of heparin is approximately 1½ hours, although this may vary considerably

from individual to individual.<sup>4</sup> Heparin is metabolized by the liver and at other sites in the body presently uncharacterized. The dosage should be diminished in patients with severe liver disease and given only with great caution if the prothrombin time is prolonged because of liver disease.

There is disagreement concerning the role of renal excretion in heparin metabolism. Both no change<sup>5</sup> and prolongation<sup>6</sup> of the half-life of heparin have been reported in uremic and anephric patients. An additional consideration in anticoagulating patients with uremia is the qualitative platelet defect, reversible by dialysis, which can predispose them to bleeding. Therefore it is safest to keep heparin dosage at the lower end of the therapeutic range.

#### *Monitoring Heparin Dosage*

Controversy surrounds the question of how to determine heparin dosage and assess response. Besides many variables which affect the accuracy of laboratory tests, there remains the problem of what is "enough but not too much" heparin. Furthermore, little is known about ideal dosage in relationship to the site of thrombosis and the individual potential for "hypercoagulability."

Because anticoagulated patients may bleed despite monitoring, some feel that monitoring tests are of little predictive value. However, most authorities recommend using the whole blood clotting time (WBCT) or the activated partial thromboplastin time (aPTT) to adjust the dosage of heparin. Either test appears reliable if properly performed. The aPTT takes less time and does not have to be performed at the bedside, but its sensitivity to heparin varies greatly with the source of the thromboplastin. The technique of performing the aPTT whether by tilt tube or an automated method, influences the result. It is important, therefore, for a laboratory to test the sensitivity and linearity of their assay system and to retest it at intervals. The therapeutic aPTT for a heparinized patient is usually given as 1½ to 2½ times the normal control, a range which may not apply to every laboratory. The usual therapeutic range for the WBCT is 2 to 3 times the control (20-30 min).<sup>7</sup>

#### *Administration of Heparin*

If pulmonary embolism or deep venous thrombosis is suspected but diagnostic procedures must be delayed, the patient may be given heparin which can be discontinued if the diagnostic studies are normal

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It has been asserted that giving heparin by continuous intravenous infusion provides the maximum combination of safety and efficacy.<sup>8</sup> Although a recent trial has failed to show a difference between continuous infusion and bolus injection.<sup>9</sup> Whether the increased safety of continuous infusion heparin is confirmed, administration of heparin by continuous infusion simplifies the obtaining of blood samples for monitoring. Continuous infusion heparin requires more nursing care if constant rate of infusion is to be maintained and the danger of overheparinization from too rapid administration avoided. This risk may be minimized by using a small 100 cc reservoir into which heparin can be placed every two hours. A continuous infusion pump may also be used. If careful observation is not possible, however, the administration of heparin every four hours by intravenous bolus injection is preferable; 24,000 to 30,000 units of heparin is given every 24 hours and a PTT or WBCT determined just before a dose is to be given.

Before a patient is given heparin, the prothrombin time (PT), aPTT or PT and a platelet count should be obtained so that pre-existing coagulopathy can be excluded. A loading dose of heparin (100 units/kg) is given and a continuous intravenous infusion begun. Fifteen U per kg per hour should be given for treatment of deep venous thrombosis while 20 U per kg per hour may be employed for patients with pulmonary embolism because of the evidence that they are initially resistant to heparin.<sup>10</sup> Usually heparin dosage in pulmonary embolism must be decreased after 24 to 48 hours as the patient's sensitivity to heparin increases. Six hours after infusion is begun, an aPTT is obtained and determined daily thereafter. The heparin dose should be adjusted to keep the aPTT between 1.5 and 2½ times the normal aPTT control. If these limits are exceeded, the aPTT should be repeated to be sure that a change has, indeed, occurred before altering dosage.

Patients with deep vein thrombophlebitis and/or pulmonary em-

bolus should be treated at least 7 to 10 days with intravenous heparin.<sup>7</sup> If warfarin is given for chronic anticoagulation, it should be started between the third and fifth days. Before warfarin is begun, a PT is obtained to be sure it is not prolonged, although a continuous infusion of heparin at therapeutic dosage does not usually prolong the PT.<sup>8</sup>

Warfarin and heparin should be given concurrently for about five days because a reliable anticoagulant effect by warfarin is not achieved for at least five days after it is started.<sup>11</sup> If the prothrombin time is then in the therapeutic range, (between 2 and 2½ times the control), heparin may be discontinued. If swelling and pain in a phlebotic leg persists or if pulmonary embolus recurs during heparin administration, the drug can be given for a longer period or other therapies employed. The patient's platelet count should be determined approximately every three days if heparin-induced thrombocytopenia is to be recognized; if this appears, heparin should be discontinued. Dextran 70 may be substituted, usually in a dose of 500 cc/day given at 100 cc/hour intravenously. Dextran has a long half-life and should not be used in patients with poor renal or cardiovascular function because of the risk of inducing fluid overload. In rare instances, Dextran has caused anaphylaxis. It is not as effective as heparin but continuing heparin administration in the face of thrombocytopenia may lead to further thrombotic complications as well as hemorrhage.<sup>12-13</sup>

#### *Complications of Heparin Therapy*

Hemorrhage, the major complication of anticoagulant therapy, can occur when the aPTT is in the proper range although it is more likely to occur when the patient has obviously been given too much heparin. Serious hemorrhage can be prevented if the stool and urine are tested regularly for blood and the hematocrit measured frequently. If blood is detected or the hematocrit drops significantly, the dosage of heparin should be reduced. Bleeding into the skin, joint spaces,

pericardium and brain can be the first evidence of excessive heparin. Thrombocytopenia, possibly immune-mediated, may occur and severe osteoporosis has been observed in patients given heparin for more than three months.<sup>14</sup> A flow sheet for recording the PT, aPTT, heparin and warfarin dosage, hematocrit, urinalysis and stool examination is essential for adequate observation and control of therapy.

#### *Low-Dose Heparin*

Heparin can be given subcutaneously in the dose of 5,000 U every 8 to 12 hours for the prevention of venous thrombosis. It is not effective for treating an established venous thrombosis but it is shown to be of value in preventing deep vein thrombophlebitis and pulmonary embolus when given preoperatively and continued until the patient is ambulatory.<sup>15</sup> It is also efficacious in preventing these complications in elderly bedridden medical patients with stroke, congestive heart failure, cancer, diabetes and myocardial infarction but is of questionable value in preventing deep vein thrombophlebitis after orthopedic surgery on the legs. When low-dose heparin is given, an aPTT should be obtained before the first dose and another shortly before the next dose to ascertain whether the patient is unusually sensitive to heparin. Low-dose heparin does not generally prolong the aPTT outside the normal range. If such a prolongation should occur in a patient scheduled for surgery, the dosage should be reduced or omitted. Low-dose heparin has been associated with thrombocytopenia as has full dose heparin.<sup>16</sup> Therefore, the platelet count in these patients should be followed closely.

#### **WARFARIN**

The most commonly used oral anticoagulant is warfarin, a coumarin derivative, although other drugs are available (Table 1). It is a vitamin K antagonist which inhibits the synthesis of biologically active factors II, VII, IX and X which are involved in both the extrinsic and intrinsic pathway of coagulation. The administration of warfarin re-

**Table 1**  
**Vitamin K Antagonists**

Drug	Trade Name
Bishydroxycoumarin	Dicumarol
Warfarin	Coumadin, Panwarfin
Acenocoumarin	Sintrom
Anisindione	Miradon

sults in the prolongation of both the PT and the PTT (Fig. 1). Traditionally, the PT has been used to assess warfarin's anticoagulant effect.

### Metabolism

Warfarin is metabolized entirely by the liver, so it should not be used in patients with severe liver disease because of unpredictable changes in its metabolism and because of the extreme sensitivity of a damaged liver to its action. Its anticoagulant action is slow in comparison to heparin because of the prolonged half-life of factors II and IX, X (72 hours and 24 hours, respectively). Factor VII, on the other hand, has a short half-life (4 hours) and the administration of large doses of warfarin completely suppresses factor VII synthesis so that its concentration approaches zero at 24 hours. This results in a markedly prolonged PT before a significant antithrombotic effect can be demonstrated.<sup>11</sup> For this reason warfarin should be given in doses of 10 to 15 mg daily until a therapeutic PT is achieved rather than by a large loading dose initially<sup>17</sup>.

### Therapeutic Use of Warfarin

Warfarin decreases the rate of recurrence of venous thromboem-

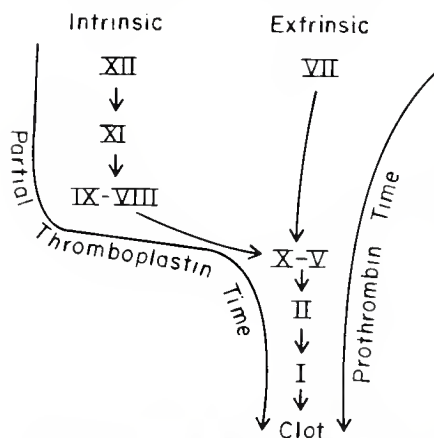


Fig. 1. The extrinsic and intrinsic coagulation pathways.

bolism in patients who have been properly treated with heparin during the acute attack.<sup>18</sup> In the uncomplicated case, this protection extends for three months after the acute episode. Thereafter, the low rate of recurrence of venous thromboembolism is the same in patients who are not taking warfarin as in those who are. For this reason, many suggest that warfarin be given for three months unless circumstances dictate a change. Keeping the PT in the therapeutic range of 2 to 2½ times control will minimize the possibility of hemorrhage.<sup>19</sup> As in monitoring heparin effect, periodic measurement of the hemoglobin and examination of urine and stool for blood is important, and women should be observed for easy bruising and menometrorrhagia. Warfarin also interacts with many commonly administered drugs<sup>20</sup> (Table 2). As few medications as possible should be

### DEFINITIONS

#### Prothrombin Time

The prothrombin time (PT) measures the integrity of the extrinsic pathway. A commercially available substitute for tissue factor (lipoprotein) is added to citrated patient plasma which is then recalcified and the time to clot formation noted. This interval is reported along with the value for a sample of normal plasma ("control value"). Normal individuals should have a PT within 3 seconds of the control.

#### Partial Thromboplastin Time

The partial thromboplastin time (PTT) measures the integrity of the intrinsic pathway. A commercially available substitute for platelet factor 3 (phospholipid) is added to citrated patient plasma and the time to clot formation noted. When an "activator" such as kaolin is also present, the test is the activated partial thromboplastin time (aPTT). The aPTT is more sensitive to heparin and more widely used. The PTT should be compared with a normal range established in each laboratory.

#### Whole Blood Clotting Time

Also called the Lee-White test, the whole blood clotting time (WBCT) measures the time necessary for freshly drawn blood to clot in a glass tube. When used to monitor heparin effect, the WBCT should be compared before and after heparin administration.

**Table 2**  
**Drug Interactions With Warfarin**

Potentiates Warfarin	Diminishes Warfarin Effect	Causes Separate Hemostatic Defects
Clofibrate	Barbiturates	Aspirin
Phenylbutazone	Glutethimide	Heparin
	Rifampin	Dextran
	Cholestyramine	Dipyridamole

given patients who are taking warfarin. Aspirin and aspirin containing compounds should be avoided, not because of their effect on the sensitivity of the patient to warfarin which is minimal at low doses, but because they induce a secondary hemostatic lesion, a qualitative platelet defect, which will increase the patient's likelihood of bruising and bleeding. Most difficulties with hemorrhage or recurrent thrombosis are related to the failure of the physician to check the PT often enough. In the beginning, weekly or twice weekly checks may be necessary. If stability is achieved, the frequency of determinations can then be reduced.

Subcutaneous heparin may be given instead of warfarin for long term anticoagulation. Here the patient is taught to inject his own heparin, the usual dose being 10,000 to 15,000 units subcutaneously, b.i.d. Studies to ascertain the effectiveness of this program are in progress.

### How and When to Reverse Anticoagulation

When heparin must be discontinued because of bleeding in a patient with normal liver function, the blood level of heparin will be practically zero after four hours. Therefore, if the hemorrhage is minor, discontinuing heparin may be sufficient. When bleeding is more serious, protamine sulfate, a basic polyamine which combines with the heparin molecule rendering it incapable of binding to antithrombin III, may be injected. Protamine sulfate, 50 mg in 5 ml bacteriostatic water for a concentration of 10 mg/ml, is given intravenously at a rate not to exceed 5 mg/min. On every milligram should be injected for every 100 units of heparin thought to be circulating. The amount of residual heparin can be estimated by



remembering that the plasma half-life of heparin is approximately 1½ hours. The injection of protamine in excess of that needed to neutralize the circulating heparin should be avoided since protamine sulfate may itself act as an anticoagulant. When the PT is excessively long, the likelihood of serious hemorrhage and the need for continued anticoagulation must be weighed. A young person with a PT in the range of 40-50 seconds, who is not bleeding, may tolerate this state well. Simply discontinuing warfarin may be all that is necessary to bring the PT into the required range. Elderly people with the PT similarly prolonged are more likely to have disastrous bleeding, especially into the central nervous system, and should be treated. If a patient requires continuing therapy, the PT may be brought into the proper range by administering fresh frozen plasma which replaces the factors II, VII, I and X. Because factor VII has a short half-life of four hours and warfarin has a half-life of 36 hours, plasma may be needed twice daily to keep the PT in the desirable range. The disadvantage of using plasma is, of course, the risk of hepatitis. If the patient no longer needs warfarin, its effect may be reversed by the administration of vitamin K. When the PT is markedly prolonged, vitamin K is usually best given intravenously since intramuscular administration may result in a hematoma. It may be given safely intravenously if 10 to 20 mg are dis-

solved in 20-30 ml fluid and given over 20 to 30 minutes. Anaphylactic reactions have occurred when vitamin K was given as an IV bolus.<sup>21</sup> Correction of the prolonged PT by this means will take 8 to 24 hours. Therefore, if the patient is bleeding heavily, the immediate administration of fresh frozen plasma, 2 to 3 units, is indicated in addition to vitamin K for immediate reversal of the prolonged PT.

### Anticoagulation Failures

Recurrent venous thromboembolism while the patient is taking heparin or warfarin should not automatically be interpreted as an anticoagulant failure. Often it will be found that the anticoagulation is inadequate. Monitoring drug dosage should assure adequate treatment. In definite anticoagulant failure, vena caval interruption may be carried out or another anticoagulant used. After inferior vena cava ligation or insertion of a vena caval umbrella, anticoagulation must be continued, if possible, because embolization may occur through collaterals that develop after the vena cava is obstructed. With warfarin failure subcutaneous heparin may be added, as may antiplatelet agents such as dipyridamole, aspirin, or sulfinpyrazone. The efficacy of such regimens has not been adequately studied. In general, vena caval interruption has fallen from favor recently because of the morbidity of surgery, post-operative complications from obstruction of

venous return and eventual development of venous collateral channels through which emboli can again pass to the lungs. The most widely accepted indication for vena caval interruption is severe thrombocytopenia or active cerebral or gastrointestinal bleeding in a patient with documented pulmonary embolus.

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I chose this Method of injecting from a perpendicular Height rather than by a Syringe, both because I was by this means assured of the Force with which the injected Cavity of the Heart was dilated, which is more uncertain with a Syringe; and also because this dilating Force from the perpendicular Height, continued acting uniformly till the Wax was grown stiff and hard. *Statistical Essays: Containing Haemastatiks* by Stephen Hales, London, 1733.



# Thyroid Function Testing: An Introduction to the Thyrotropin-Releasing Hormone (TRH) Stimulation Test

Denis I. Becker, M.D.

**ABSTRACT** The recently introduced thyrotropin-releasing hormone (TRH) Stimulation Test has proven useful in the evaluation of many types of thyroid disease permitting more accurate diagnoses and facilitating definitive therapy. Three cases which demonstrate its value to practicing physicians are presented.

## INTRODUCTION

THYROID function testing, with indirect measurement of free thyroxine secretion (as with the total thyroxine), circulating thyroid-binding globulin (the  $T_3$  uptake test), and thyrotropin (TSH) secretion permits diagnosis of most cases of hypothyroidism — primary (thyroprivic), secondary (pituitary), or tertiary (hypothalamic). Radioiodine uptake is rarely needed in the diagnosis of thyroid hypo- and hypersecretory states except when hyperthyroidism is associated with thyroiditis or thyroid hormone administration. The  $T_3$  concentration can help elucidate those cases of  $T_3$  toxicosis. Antithyroglobulin and antimicrosomal antibodies and the sedimentation rate are useful in the evaluation of patients with thyroid-

itis (which can present as hyperthyroidism). Lastly, thyroid scanning with iodine isotopes 131 or 123, or Pertechnetate is useful in evaluating a thyroid nodule or when occult thyroid malignancy is suspected.

Few other tools are needed for confident evaluation of potential thyroid pathophysiology. The PBI is occasionally useful in evaluating thyroiditis (or states of exogenous iodine excess) when compared to a simultaneously obtained total  $T_4$ . The perchlorate discharge test may be useful in evaluating goiterous patients. Assays for reverse  $T_3$  are being used, along with TSH and  $T_4$  assays, to screen for congenital hyperthyroidism. Assays for LATS are being used in selected patient groups in the evaluation of Graves' disease. The TSH stimulation test occasionally gives valuable information when used in association with the radioiodine uptake study and scanning. The  $T_3$  suppression test is a classical tool to evaluate patients with suspected autonomous thyroid function.

While the  $T_3$  suppression test is not identical to the thyrotropin-releasing hormone (TRH) stimulation test, it has been virtually supplanted by this latter procedure. It is the purpose of this paper to further acquaint the clinician with

the TRH stimulation test, with specific emphasis on its utility facilitating definitive diagnosis in the office.

## THE TRH STIMULATION TEST

An understanding of the TRH stimulation test is contingent upon familiarity with the principle governing regulation of most endocrine glands: negative feedback. Thyrotropin releasing hormone, a hypothalamic factor, is released to stimulate the anterior pituitary secretion of thyroid stimulating hormone (TSH) which in turn promotes thyroxine synthesis and release from the thyroid gland. In states of thyroxine deficiency (as in primary hypothyroidism) TSH is elevated; conversely, in states of thyroxine excess (as in either primary hyperthyroidism or iatrogenic hyperthyroidism) the secretion of TSH is suppressed. In this latter condition administration of exogenous T<sub>4</sub> cannot bring about TSH secretion while in states of thyroxine depletion, there is an exaggerated response of the pituitary to TRH stimulation.<sup>1</sup> The test is performed with the patient supine, with frequent blood pressure recordings to monitor the often significant transient hypertension following administration. The patient is

615 St. Mary's Street, Raleigh, N.C. 27605.

formed that nausea or flushing is often momentarily experienced. TRH\* is rapidly injected intravenously in a dosage of 500 mcg with venous sampling done before the injection and again at 30 minutes for TSH assay.

### USES OF THE TRH STIMULATION TEST

One of the most useful indications for the TRH stimulation test is to clarify the diagnosis of hyperthyroidism<sup>2</sup> (whether due to thyroiditis or exogenous administration of thyroid hormone.) The T<sub>4</sub> suppression test, which has been used to confirm the diagnosis of autonomous thyroid function, is often hazardous, as with an elderly patient with suspected thyrocardiac disease.<sup>3</sup> The TRH stimulation test can lead more quickly to a definitive diagnosis, with little risk to the patient. In thyroxine excess there will be no increase in circulating TSH after TRH administration. This reflects the negative feedback suppression of pituitary responsiveness. Cases 1 and 2 demonstrate the utility of the TRH stimulation test in clarifying the diagnosis of possible hyperthyroidism, thus allowing the physician to recommend definitive therapy.

#### CASE HISTORY NO. 1

E. F., a 59-year-old female with a 10-year history of back pain, was seen by her orthopedic surgeon who stated that the patient felt that she was getting shorter. There was no history of weight loss, palpitations, heat intolerance or change in bowel habit. On physical examination she was extremely frail, exhibited marked dorsal kyphosis, and appeared older than her stated age. Her heart rate was 90 and regular. Her skin was dry and her thyroid was finely nodular and symmetric weighing about 25 gms. The T<sub>4</sub> by radioimmunoassay was 14.0 mcg/dl (normal 4-12), T<sub>3</sub> uptake 51% (normal 38-58) and a 24-hour radioactive iodine uptake was 30%. The baseline TSH level was 3.9 mIU/ml

and the value 30 minutes after 500 mcg of TRH was 3.7 mIU/ml. This was interpreted to be consistent with the patient's hyperthyroidism which was thought to be contributing to her severe postmenopausal osteoporosis, demonstrated radiographically. After definitive treatment with 6 mCi of radioactive iodine, the patient became euthyroid, her strength improved, and her back pain resolved.

#### CASE HISTORY NO. 2

L.T., a 32-year-old female, presented with the chief complaint of increasing nervousness of eight years duration. She was referred by her gynecologist, who has been seeing her for dysmenorrhea, because of a history of recent weight loss of six pounds and complaints of increased perspiration. The results of a screening thyroid panel (including T<sub>4</sub> by radioimmunoassay and T<sub>3</sub> uptake) were reported to be at the upper limits of normal. Approximately two weeks before being seen in consultation she had had a normal oral cholecystogram for the evaluation of abdominal pain. Her blood pressure was 114/78, heart rate 100 and regular, her skin was dry, there was no tremor, and her thyroid was normal to palpation. A baseline TSH was 1.8 mIU/ml and the TSH level 30 minutes after TRH 500 mcg I.V. was 20.2 mIU/ml. While this patient might have been hyperthyroid before this evaluation, as with hyperthyroiditis, the TRH stimulation test conclusively ruled out thyroid disease and allowed her physician to focus on the treatment of her anxiety.

Hypothyroidism may be a very subtle diagnosis. When total T<sub>4</sub> and T<sub>3</sub> resin uptake are depressed, with inappropriately low TSH, hypothalamic hypothyroidism may be differentiated from pituitary hypothyroidism by the TSH response to TRH administration.<sup>4</sup> A more common indication for the TRH stimulation test is the evaluation of a patient with symptoms suggesting hypothyroidism, who presents with a low normal T<sub>4</sub> and a high normal TSH determination. An exaggerated response to TRH may be

the most sensitive indicator of early hypothyroidism in this instance. Case 3 is a good example of this.

#### CASE HISTORY NO. 3

M.P., a 50-year-old female with multisystemic nonspecific complaints, had a routine thyroid screening panel when she mentioned that she had discontinued her long-standing thyroid replacement therapy years earlier; she had not accepted the reassurances of her personal physician that there was no proved association between breast cancer and thyroid hormone therapy. Her physical examination was entirely normal. Her T<sub>4</sub> by radioimmunoassay was 4.9 mcg/dl (normal 4-12), T<sub>3</sub> uptake was 47% (normal 38-58). Her TSH was 10.5 mIU/ml (normal 0-12). Her borderline low T<sub>4</sub> associated with the borderline high TSH led to a TRH stimulation test with a baseline TSH value of 8.8 mIU/ml and a 30-minute specimen for TSH which was reported to have greater than 100 mIU/ml. This was considered to be an excessive response, indicative of early thyroid insufficiency, and the patient was given a lifetime prescription for L-thyroxine, 0.15 mgm daily, with a detailed explanation of the controversy regarding thyroid hormone replacement and breast cancer.

In patients taking average maintenance doses of thyroxine replacement therapy, especially those with histories of significant cardiac disease, the TRH stimulation test may also serve to evaluate the adequacy of replacement therapy when symptoms of hypothyroidism persist.

It should be appreciated that TRH stimulation is also followed by a rise of triiodothyronine about three hours after administration, so that T<sub>3</sub> measurement can provide an alternative index of thyroid responsiveness.<sup>5</sup> Release of prolactin is also consistently stimulated by TRH administration, so that it may be assayed in the evaluation of the hypothalamic-pituitary axis.<sup>6</sup> Finally, although the TRH stimulation test gives information similar to the traditional T<sub>3</sub> suppression test, the two tests are not identical. For in-

\*Thyreline (Thyphine) is the synthetic tripeptide believed to be structurally identical with naturally-occurring thyrotropin-releasing hormone and is supplied by Abbott Laboratories, Chicago, Illinois.

stance, it is entirely possible for a patient with Graves' disease treated by subtotal thyroidectomy to have an autonomous remnant which is insufficient to render the patient even euthyroid. In this case the patient could have a negative T<sub>3</sub> suppression test reflecting the autonomy, yet have a response to TRH administration, reflecting the lack of TSH suppression.<sup>7</sup>

It is the rapidity, convenience, safety and absolute definitiveness

of the TRH stimulation test that recommends it to the diagnostician. While most cases of thyroid disease can be diagnosed by tests such as total T<sub>4</sub>, T<sub>3</sub> uptake, and TSH, this relatively new test, available for little more than a year, will better define problems that previously were either undiagnosed or merely approached empirically.

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Now this Velocity is only the Velocity of the Blood at its first entering into the *Aorta*, in the Time of the *Systole*; in consequence of which the Blood in the Arteries, being forcibly propelled forward, with an accelerated *Impetus*, thereby dilates the Canal of the Arteries, which begin again to contract at the instant the *Systole* ceases: By which curious Artifice of Nature, the Blood is carried on in the finer Capillaries, with an almost even Tenor of Velocity, in the same manner as the spouting Water of some fire-Engines, is contrived to flow with a more even Velocity, notwithstanding the alternate *Systoles* and *Diastoles* of the rising and falling *Embolus* or Force: and this by the means of a large inverted Globe, wherein the compressed Air alternately dilating or contracting, in Conformity to the workings to and fro of the *Embolus*, and thereby impelling the Water more equably than the *Embolus* alone would do, pushes it out in a more nearly equal Spout. — *Statistical Essays: Containing Haemastatics* by Stephen Hales, London, 1733.



# *Editorials*

## **MANNING THE DOGMATIC STATIONS**

*No man, however strong, can serve ten years as schoolmaster, priest, or senator and remain fit for anything else. All the dogmatic stations in life have the effect of fixing a certain stuffiness of attitude forever, as though they mesmerized the subject.*  
—Adams, Henry. *The education of Henry Adams*. 918.

One of the phenomena of our day is a renewed appreciation of the physical body, sometimes at the expense of the spiritual one. Psychiatrists have told us that our bodies speak to us through symptoms which if interpreted correctly can often clarify difficulties and even purify our thoughts. In the abortion argument a woman is said to have a right to her own body which allows her to share it with a man and even to reject the consequences of such a union. If this position be extended, it then permits the acceptance of suicide as a legitimate means of disposing of one's body and for relieving life's vagaries and vicissitudes.

By appropriating the term pro-life, those opposing abortion have of course scored a verbal point; their opponents can hardly afford to be characterized as anti-life. But we should not be deceived by such chimeras. Political platforms are made of planks labelled God, Country and Motherhood by carpenters who

often don't know a plane from a level. Of contending about these problems there will be no end but there does need to be some place or state of mind in the United States where the uncertain, the hesitant or even the thoughtful can seek asylum for the sifting of the thundering herd of data hurled at us and for the identification of the chaff which must be blown away so that the wisdom of our body can be headed. For there is a wisdom of the body which has evolved through time; it speaks softly and encourages the recognition of limits. It asks for sound hypophyses capable of examination, pleads for verifiable data, appreciates reproducibility and recognizes that failure must be identified so that programs encouraging it can be abandoned. In an age of social engineering, it is saddening to realize that most of our political bodies and our activists are not concerned about developing ways to find out whether any of our programs are really succeeding. If we as physicians were so slipshod in caring for our patients, we could hardly survive in the marketplace. If we are to help others learn of the wisdom of their own bodies, it is necessary that we, unlike priests, educators and Army officers, avoid the dogmatic stations in life and resist unfortunate fashions in modern medicine.

J.H.F.

# Bulletin Board

## NEW MEMBERS of the State Society

Barber, Tracy Ezra, MD, (OM) Route #1, Box 5, Lexington 27292  
 Bell, William Reed, Jr., MD, (INTERN-RESIDENT) 2013 Pershing St., Durham 27705  
 Bennett, Ms. Stephanie Rae (STUDENT) 250 S. Estes Drive, Chapel Hill 27514  
 Brantly, Edgar Clayton, Jr., MD, (IM) 323 Bethel Drive, Salisbury 28144  
 Brecht, Ms. Kathryn Lynn Press (STUDENT) 3502-1 Wimberly Ln., Winston-Salem 27106  
 Brown, David Robert, MD, (AN) Route #4, Box 416, Chapel Hill 27514  
 Cannon, Woodward, MD, (GS) 1300 St. Mary's St., Raleigh 27605  
 Catlin, Roger William, MD, (AN) 4630 Grinding Stone Dr., Raleigh 27604  
 Daly, John Thomas, MD, (PTH) P.O. Box 15337, Durham 27704  
 Dugan, Michael Joseph, MD, N. Ivy Avenue, Siler City 27344  
 Edkins, Ms. Patricia Teague, (STUDENT) 724 Poplar Street, Carrboro 27510  
 Faber, Mr. David Ray, II (STUDENT) Route #3, Box 94-A, Greenville 27834  
 Faison, Ms. Hattie Mae (STUDENT) 4216 Garrett Rd. Apt. 1-30, Durham 27705  
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 Johns, Mr. Peter Mercer (STUDENT) 22-C Langston Park, Stancill Dr., Greenville 27834  
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 Lanier, Verne Clifton, Jr., MD, (PS) 1320 Broad St., Durham 27705  
 Lee, Mr. Kenneth Stuart, (STUDENT) P.O. Box 2044, Greenville 27834  
 More, Joseph, MD, (P) 1106 Rollingwood Street, Wilson 27893  
 Nemeroff, Mr. Charles Barnet (STUDENT) Rt. #3, Box 240, Chapel Hill 27514  
 Powell, Mr. Bayard Lowery (STUDENT) 108 Henderson St., Chapel Hill 27514  
 Rice, John Russell, MD, (RHU) Box 3383, Duke Medical Center, Durham 27710  
 Slotnick, Lawrence Sheldon, MD (PUD) 1018 N. Elm St., Greensboro 27401  
 Vaughn, Richard Sidney, MD, (FP) #7 Doctor's Park, Greenville 27834

## WHAT? WHEN? WHERE? In Continuing Education

Please note: 1. The Continuing Medical Education Programs at Bowman Gray, Duke, East Carolina and UNC Schools of Medicine, Dorothea Dix, Wayne County Hospital and Burroughs Wellcome Company are accredited by the American Medical Association. Therefore CME programs sponsored or co-sponsored by these schools automatically qualify for AMA Category 1 credit

toward the AMA's Physician Recognition Award, and for North Carolina Medical Society Category A credit. Where AAFP credit has been requested or obtained, this also is indicated.

2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information."

## PROGRAMS IN NORTH CAROLINA

### October 2-6

Microvascular Surgery Workshop

Credit: 40 hours

For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

### October 4-5

Annual Charlotte Postgraduate Seminar

Place: Charlotte Memorial Hospital

Fee: None

Credit: 12 hours

For Information: Richard Kerecman, M.D., P.O. Box 795, Huntersville 28078

### October 4-5

Seminar on Diabetes

Fee: None

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### October 12

Recent Advances in the Treatment of Malignant Hyperthermia

Place: Burroughs Wellcome Company

For Information: Stanley Grosshandler, M.D., Director of Continuing Education, Burroughs Wellcome Company, Research Triangle Park 27709

### October 12-14

North Carolina and South Carolina Orthopedic Association Annual Meeting

Place: Pinehurst Hotel and Country Club, Pinehurst

For Information: Cecil Neville, M.D., Pinehurst Surgical Center, Pinehurst 28374

### October 13-14

Alumni Scientific Session

Fee: None

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### October 13-14

Practical Ophthalmology and Primary Care

Place: Islander Motor Hotel, Emerald Isle Beach

For Information: David Eifrig, M.D., Department of Ophthalmology, UNC School of Medicine, Chapel Hill 27514

### October 13-15

Update in Obstetrics and Gynecology

Place: Blockade Runner Motor Hotel, Wrightsville Beach

For Information: Luther Talbert, M.D., Department of Obstetrics and Gynecology, UNC School of Medicine, Chapel Hill 27514

### October 16-18

North Carolina Office of Emergency Medical Services Annual Meeting

Place: Sheraton Inn, Charlotte

For Information: Mr. Chris Gentile, North Carolina Office of Emergency Medical Services, 1330 St. Mary's Street, Raleigh 27611



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**October 17-22**

th Annual Workshop and Scientific Program of the Society for Clinical and Experimental Hypnosis  
 Place: Grove Park Inn, Asheville  
 Sponsors: Department of Psychiatry and the Department of Psychology of UNC and the Office of Continuing Education, UNC School of Medicine, and the School of Dentistry  
 For Information: Shirley Sanders, Ph.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

**October 18**

Recent Developments in Gastroenterology  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 5 hours; AMA Category 1  
 For Information: F.M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

**October 27-28**

Cardiovascular Medicine and Surgery: A Harvey Quartercentenary Meeting  
 Credit: 11 hours  
 For Information: M. Henderson Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

**October 27-28**

Second Annual Hospice Symposium  
 Place: Royal Villa, Greensboro  
 For Information: Hospice of North Carolina, P.O. Box 11452, Winston-Salem 27106

**November 2-4**

ambulatory Pediatric Society Meeting  
 For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

**November 8**

Practical Pediatrics"  
 Place: Pitt County Memorial Hospital, Greenville  
 Credit: 3 hours; AMA Category 1  
 For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

**November 10**

Seminar on Aging  
 Fee: \$35  
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

**November 16-18**

th Annual Scientific Assembly of the North Carolina Academy of Family Physicians  
 Place: Sheraton Inn, Charlotte  
 Fee: \$30  
 For Information: Mr. Edwin Davis, Executive Director, North Carolina Academy of Family Physicians, P.O. Drawer 11268, Raleigh 27604

**November 29**

nutrition in Medical Care 1978  
 Place: Lee County Hospital, Sanford  
 Sponsors: Lee County Medical Society and Eaton Laboratory  
 Fee: \$6.00 for non-M.D.'s  
 Credit: 3.5 hours  
 For Information: R. S. Cline, M.D., Director of Continuing Medical Education Lee County Hospital, Sanford 27330

**December 1-2**

American College of Physicians — North Carolina Society of Internal Medicine Annual Meeting  
 Place: Sheraton Inn, Charlotte  
 For Information: Norman H. Garrett, M.D., 1038 Professional Village, Greensboro 27401

**December 2**

Pregnancy, Birth, and Infancy: Origins of Attachment  
 For Information: Emery C. Miller, M.D., Associate Dean for Con-

tinuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

**December 11-15**

Industrial Toxicology  
 For Information: Mario Battigelli, M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

**December 13**

Office Gynecology  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 3 hours; AMA Category 1  
 For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

**January 10**

Immunological Aspects of Malignancy  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 3 hours; AMA Category 1  
 For Information: F. M. Simmons Patterson, Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

**January 26-27**

Clinical Urology  
 Place: Bahcock Auditorium  
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

**February 1-3**

Womack Surgical Society Meeting  
 Place: Berryhill Hall  
 For Information: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill 27514

**February 2-3**

North Carolina Conference for Medical Leadership  
 Place: Sheraton Crabtree Motor Inn, Raleigh  
 Sponsors: North Carolina Medical Society  
 For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

**February 14**

Psychopharmacology Update  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 3 hours; AMA Category 1  
 For Information: F.M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

**February 16-20**

Basic Electroencephalography  
 Credit: 30 hours  
 For Information: Malcolm H. Rourke, Jr., M.D. Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

**February 19-23**

Microvascular Surgery Workshop  
 Credit: 40 hours  
 For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

**March 9-10**

Frank R. Lock Symposium in Obstetrics and Gynecology  
 Place: Bowman Gray School of Medicine  
 For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

**March 14**

Recent Advances in Surgical Care  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 3 hours; AMA Category 1  
 For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834



## ITEMS OF SPECIAL INTEREST

### October 21-22

AMA Regional Continuing Medical Education Program  
Place: The Great Smokies Hilton  
Credit: 12 hours  
For Information: AMA Department of Meeting Services, 535 North Dearborn Street, Chicago, Illinois 60610

### October 23-27

Current Concepts in Diagnostic Radiology  
Place: Southampton Princess Hotel, Bermuda  
Fee: \$250  
Credit: 30 hours  
For Information: Robert McLelland, M.D., Radiology — Box 3808, Duke University Medical Center, Durham 27710

### October 26-29

Annual Fall Meeting, North Carolina Society of Internal Medicine  
Place: Kiawah Island, South Carolina  
For Information: Jack B. Hobson, M.D., 1351 Durwood Drive, Charlotte 28204

### December 7-10

Thirty-Second American Medical Association Winter Scientific Meeting  
Place: Las Vegas  
For Information: Department of Meeting Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

### February 12-16

Current Concepts in Diagnostic Radiology  
Place: Acapulco Princess Hotel, Mexico  
Sponsor: Department of Radiology, Duke University Medical Center  
Fee: \$250  
For Information: Robert McLelland, M.D., Radiology Box 3808, Duke University Medical Center, Durham 27710

## PROGRAMS IN CONTIGUOUS STATES

### October 4-6

Recent Advances in Pulmonary Medicine  
Place: University of Tennessee Center for the Health Sciences, Memphis  
Credit: 15 hours; Category 1  
For Information: Mrs. Grace Wagner, Conference Coordinator, University of Tennessee Center for the Health Sciences, 800 Madison Avenue, Memphis, Tennessee 38163

### October 27-28

Southeastern Regional Meeting, American College of Physicians  
Place: Savannah Inn and Country Club, Savannah, Georgia  
For Information: Nicholas E. Davies, M.D., FACP, 35 Collier Road N.W., Atlanta, Georgia 30309

### November 2-3

Clinical Evaluation and Management of Chronic Pain  
Place: University of Tennessee Center for the Health Sciences, Memphis  
Credit: 10 hours; Category 1  
For Information: Mrs. Grace Wagner, Conference Coordinator, University of Tennessee Center for the Health Sciences, 800 Madison Avenue, Memphis, Tennessee 38163

### November 5-8

Second Annual Symposium on Computer Applications in Medical Care  
Place: Washington, D.C.  
Sponsors: Medical College of Virginia Department of Continuing Medical Education, George Washington University Medical Center, Georgetown University Medical School, IEEE Computer Society  
For Information: Department of Continuing Medical Education, Medical College of Virginia, MCV Station, Richmond, Virginia 23298

The items listed in the above column are for the six months immediately following the month of publication. Requests for listing should be received by "WHAT? WHEN? WHERE?", P.O. Box 27167, Raleigh 27611, by the 10th of the month prior to the month in which they are to appear. A "Request for Listing" form is available on request.

## AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

### INAUGURAL REMARKS MAY 6, 1978

The definition of a good speech — is a beginning and a conclusion not too far apart.

I accept this overwhelming responsibility as your president with a great feeling of humility and respect for those who have preceded me. As president-elect this past year I have attempted to learn as much as I can from Mary Leila Andrews, Martha Martinat and any of our past presidents I could reach by telephone or letter. I thank all of you for your patience and counsel.

Our immediate past president, Mary Leila Andrews, has had a tremendously successful year. She has been so good to keep me informed of all plans and projects helpful to me this next year. Her warmth of personality and her tireless efforts on our behalf have endeared her to all who have met her here in North Carolina and nationally. She never gets hurried or ruffled or impatient. I thank her, as we all should, for her graciousness in representing North Carolina, even though she first called South Carolina as home.

Each of our presidents has added special flavoring to her leadership. It will be hard to live up to the contributions these ladies have made.

I believe our theme for the coming year — "Our Adolescents — Their Changing World" — is both timely and of great importance to the development of these fully-matured citizens. Our youth of today face more temptations, frustrations and challenges than ever before. The media, through violence, sex, and outspoken interviews with controversial people, are constantly flinging subjects at them that many of us used to keep within the family unit for discussion and mediation. Communications within the family are suffering due to the fast pace of our social activities and school activities outside the home. Our physician spouses' hours at home are undependable due to the nature of their profession. Everyone eats at a different time and sometimes a different place. The frequent adolescent rebellion against parental authority must have a reason and therefore an answer. Perhaps we can come to understand it this year with further study and emphasis on these problems.

Membership is more vital now than ever before. We have more than 4,100 practicing physicians in North Carolina and 2,922 auxiliary members. So 1,200 are missing from our rolls. I hope we will find and interest many of these valuable individuals this coming year. We now have 10 delegates to the national convention. Shall we try for 11?

Legislation adverse to medicine is creeping closer and closer. We have to wake up to this fact before it is too late. Our physician husbands or wives have to wake up to this fact before it is too late. We can no longer sit back and let George or Jenny do it — or leave



the management of the practice of medicine to the professional politician. We must get out and work at the precinct level for candidates friendly to medicine. You can easily find out who these candidates are. Write letters, send telegrams and make personal visits to show your support. It is not always easy for them to fight for what they believe is right. But do get involved. The saying goes, "They are going to do it or not"; but by being involved we can make it more palatable for the sake of high quality medical care.

We have come a long way from the strictly social gatherings, even though these certainly are fun and have an important place in our lives. Many of our members now serve on the boards of schools, churches and hospitals. We are leaders in civic organizations. In some states across the country, auxiliary members serve in their state house or senate. Why can't that come about in North Carolina? We certainly have the material and the know-how.

We work for the Red Cross and we are active in hospital auxiliaries. We work with mental health organizations and reach to recovery programs. We sponsor child abuse programs and have developed fantastic health museums for the education of our youth. We fought for the life of the School Health Education Bill providing a trained health education coordinator in each school system in the state. So we are a busy, productive organization.

The American Medical Association Educational and Research Fund (AMA-ERF) continues to need our strong support. Contributions to this fund go to our medical schools to provide assistance for their programs directed primarily toward improving the background of medical students. Many of these students would have difficulty continuing their studies without the support of AMA-ERF. Each dollar contributed provides \$12 in low-interest loans to students.

So you can see, we have a great legacy to build on — let's do it! It will take all of us working together. No job is small or meaningless. It takes many spokes to keep the wheels of progress moving forward.

I would like to thank those who have accepted board positions and the officers you have chosen to serve with me. A leader is only as strong as those who surround her. However, she must remember to look back to be sure there are still followers.

I would also like to publicly thank Mr. Hilliard, LaRue King and the headquarters staff for their support this past year and I ask for their counsel during the next 12 months. It will be deeply appreciated.

Do let me come and visit you. I have had a great time this year at the meetings I have attended so far. I have managed to get myself lost four times and barely escaped receiving a speeding ticket, but I have only been locked in the ladies room once.

With the encouragement of my family and our friends, I hope to represent the North Carolina Medical Society Auxiliary with humility and dignity. The former is no problem but the latter might be. I have a special friend who has so much confidence in me that

she gave me a book of blunders just so I won't be perfect.

I will close with the story of the daughter of a famous surgeon who always introduced herself as Dr. Baker's daughter. Her mother decided to correct her, on the grounds that it sounded somewhat snobbish. "After this," her mother instructed her "just refer to yourself as Mary Jane Baker." Several days later a colleague of the physician visiting in their home asked, "Aren't you Dr. Baker's daughter?" "I always thought I was," the girl responded, "but my mother says not!"

MRS. ROBERT L. MEANS, President

#### News Notes from the—

### **BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY**

The Bowman Gray School of Medicine has made 10 appointments to the fulltime and seven appointments to the part-time faculty.

Appointed to the fulltime faculty are Dr. James A. Burdette, professor of family medicine; Shirley S. Crump, instructor in anesthesia (nurse anesthesia); Dr. J. Charles Eldridge, assistant professor of physiology and pharmacology; Dr. Barry T. Hackshaw, instructor in medicine (cardiology); Dr. James Alan Koufman, instructor in surgery (otolaryngology); Dr. Maw-Shing Liu, associate professor of physiology; Dr. Ian A. MacPhail, associate professor of family medicine; Dr. Bradley B. F. Sakran, assistant professor of family medicine; Dr. David W. Strevel, instructor in dentistry and instructor in health systems analysis; and Dr. Edward H. Stullken, Jr., assistant professor of anesthesia.

Those appointed to the part-time faculty are Dr. Thavij David Burapavong, clinical instructor in surgery (plastic surgery); Dr. James M. Cooper, clinical instructor in obstetrics and gynecology; Dr. Francis B. Dove, Jr., associate in medicine; Dr. Richard C. Finn, clinical instructor in obstetrics and gynecology; Dr. William A. Hough III, clinical instructor in medicine; Dr. W. Thomas Rowe, clinical instructor in medicine (rheumatology); and Dr. Michael H. Rubin, clinical instructor in medicine (gastroenterology).

\* \* \*

Grant from the National Science Foundation will permit new research at Bowman Gray on how a virus is able to transfer genetic material from one living cell to another and how the body produces and regulates a hormone which influences blood pressure.

A two-year, \$39,782 grant has been made to Dr. Henry Drexler, professor of microbiology, to study the transfer of genetic material from one bacteria to another using the T1 virus.

Dr. Kenneth A. Gruber, assistant professor of

physiology, has received a two-year, \$53,916 grant to study a hormone, vasopressin.

\* \* \*

A substance which helps prevent the rejection of transplanted kidneys will be available to North Carolina hospitals as a result of a new program developed at Bowman Gray.

Kidney transplant programs at North Carolina Baptist and Charlotte Memorial Hospitals will be the first to use the Bowman Gray-produced substance, called Anti-Thymocyte Globulin (ATG).

The new program involves making, testing and distributing ATG as well as a clinical research project to determine exactly how ATG should be used for maximum patient benefit.

The ATG will be obtained from rabbit serum. Studies done elsewhere have shown that ATG produced in rabbits is well tolerated and effective.

ATG acts against a type of white blood cell, T-lymphocyte, which is a key to the kidney-rejection process.

The use of ATG permits physicians to reduce the dosage of the two drugs most commonly used to fight kidney rejection. Those drugs tend to make the body more susceptible to infection and to certain types of cancer.

\* \* \*

Dr. Vardaman M. Buckalew, professor of medicine and physiology, will conduct research on a rare, inherited disease through a grant from the March of Dimes.

The one-year birth defects research grant will allow work on renal tubular acidosis (RTA).

Because of work Buckalew has done in the past, he believes he has found a clue as to why there is an excess of calcium in the urine of RTA's victims.

Through testing the relatives of patients with RTA, he found that there is an abnormally high absorption of calcium from some children's diets. Early long-term exposure to that excess calcium plus a genetic predisposition to RTA could lead to the disease.

Buckalew will test his idea about calcium from the diet through metabolic studies and will compare the safety and effectiveness of different drug treatments aimed at controlling calcium excretion.

\* \* \*

Dr. Eben Alexander, Jr., professor of neurosurgery, has been elected to serve on the Council on Medical Education of the American Medical Association.

\* \* \*

Dr. Ed Byrum, Jr., assistant professor of surgery (emergency medicine), has been appointed to the committee to work with the North Carolina Industrial Commission by the North Carolina Medical Society.

\* \* \*

Dr. Robert J. Cowan, associate professor of radiology, was elected chairman of the Section on Nuclear

#### Brief Summary of Prescribing Information Combined TEGOPEN® (cloxacillin sodium)

##### Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) TEGOPEN 9/11/7

**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.


**Usual Dosage:** Adults: 250 mg. q. 6h.  
Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

**N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.**

**Supplied:** Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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# IN THE NORTH CAROLINA AREA, STAPH RESISTANCE HAS NOW REACHED 72%.\*

resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

## TEGOPEN<sup>®</sup> (cloxacillin sodium)

“THE PENICILLIN OF TODAY”

Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

10 times more active against strep than staph.

Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary  
for prescribing information.



Medicine at the annual meeting of the North Carolina Medical Society.

\* \* \*

Dr. Robert A. Diseker, associate professor of community medicine, has been presented a Community Service Award by the Forsyth Health Planning Council for leadership and dedicated service as a member of the Board of Directors.

\* \* \*

Dr. Charles H. Duckett, associate professor of family medicine, has been reappointed chairman of the North Carolina Medical Society Insurance Industry Committee.

\* \* \*

Kate Garner, instructor in human development, has been appointed to the steering committee for the Governor's Conference on Youth, 1978-79.

\* \* \*

Patricia Gibson, instructor in pediatric neurology, has been appointed chairman of the Education Committee of the Professional Advisory Board of the Epilepsy Association of North Carolina. She also has been elected to the Board of Directors of the Northwest North Carolina Epilepsy Association.

\* \* \*

Dr. Frederick Glass, associate professor of surgery (emergency medicine), has been appointed to the North Carolina Medical Society's Committee on Disaster and Emergency Medical Care; Committee on Blue Shield-Professional Service Commission; and the Committee on Hospital and Professional Relations-Professional Service Commission.

\* \* \*

Gale L. Harkness, instructor in community medicine (allied health), was appointed chairman of planning for the 1979 annual conference for the North Carolina Academy of Physician Assistants to be held in Winston-Salem.

\* \* \*

Dr. James C. Leist, assistant professor of community medicine, has been re-elected chairman of the Regional Continuing Education Committee, North Central Region, Division of Mental Health Services, Department of Human Resources.

\* \* \*

Dr. James G. McCormick, research associate professor of otolaryngology, is the new president-elect of the North Carolina Chapter of the Society for Neuroscience.

\* \* \*

Dr. Jesse H. Meredith, professor of surgery, has been reappointed chairman of the Cost Containment

Committee of the North Carolina Medical Society. He also was re-appointed to membership on the society's Insurance Industries Committee.

\* \* \*

Dr. Isadore Meschan, professor of radiology, received the Gold Medal Award from the American College of Radiology, meeting in San Diego, Calif.

\* \* \*

Dr. Richard T. Myers, professor and chairman of the Department of Surgery, was elected vice president of the North Carolina Chapter of the American College of Surgeons at the organization's spring meeting at Wrightsville Beach.

\* \* \*

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, and Dr. David J. Goode, associate professor of psychiatry, have been appointed to the board of directors of the North Carolina Foundation for Mental Health, Inc.

\* \* \*

Celia Snaveley, instructor in medicine (medical social work), has been elected to the board of trustees of the Kidney Foundation of North Carolina, 1978-79.

\* \* \*

Dr. Richard W. St. Clair, professor of pathology (physiology), has been asked to serve as a member of the National Heart, Lung and Blood Institute's Research Review Committee B for a four-year term.

\* \* \*

Dr. Mary A. Taylor, assistant professor of community medicine, has been appointed to the Medical Education Committee of the North Carolina Medical Society.

#### News Notes from the

### UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

Recipients of the 1978 Morehead Fellowships in medicine at Chapel Hill are Stanley Spencer Hamaker of Richmond, Va., Constance M. Kalinowski of Locust Valley, N.Y., and Kathi Kemper of Vienna, Va. Morehead Fellowships are valued at \$3,500 a year plus tuition and fees for four years of study.

The UNC-CH Morehead medical fellowships were established in 1966 by the John Motley Morehead Foundation. They are awarded annually to attract students of superior academic ability, leadership potential and character who are highly motivated toward

the field of medicine and who show promise of distinction in that field.

\* \* \*

The university has been notified by the National Institutes of Health of approval of a grant application for more than \$1.9 million to assist the School of Medicine's long-standing research program in disorders of blood coagulation.

The grant, to be funded for five years beginning next January, is the renewal of a program of research that began in 1961.

Principal investigator of the program, "Structure-Function and Genetic Studies of Factors VIII and IX," is Dr. John B. Graham, alumni distinguished professor of pathology. The grant will support the research activities of 13 faculty members associated with his division of research in thrombosis and hemostasis of the pathology department.

The researchers will be investigating blood-clotting factors linked to hemophilia. The research is expected to shed light on thrombosis also.

Drs. Emily Barrow, Robert Elston, Howard Reisner and Graham will investigate the genetics of Factors VIII and IX, looking especially at the frequencies of the genes causing hemophilia, where they are located on the chromosomes and how to identify their carriers.

Researchers examining the chemical structure and biological function of Factor IX by comparing genetic variants of this enzymic clotting factor with the normal factor include Drs. Harold Roberts, Roger Lundblad, Frederick Dombrose, Howard Reisner, Claudia Noyes, Henry Kingdon, Kuo-San Chung and Jonathan Goldsmith.

Drs. Robert Wagner and Herbert Cooper will continue their fundamental biochemical studies of the structure of Factor VIII and its reactions with platelets. Dr. Kingdon will attempt to modify Factor VIII chemically in order to improve its therapeutic properties.

\* \* \*

Faculty, students and house staff were honored for their outstanding achievements at the school of medicine's annual Student/Faculty Day celebration.

Faculty and house staff recipients and their awards are: Dr. John C. Parker, professor of medicine, The Professor Award; Dr. Frederick G. Dalldorf, professor of pathology, Basic Science Teaching Award; Dr. J. Logan Irvin, professor and chairman of biochemistry and nutrition, the Central Carolina Bank Excellence in Teaching Award; Dr. Robert C. Hartmann, third-year resident in medicine, the Henry C. Fordham Award; and Dr. Francis S. Collins, first-year resident in medicine, the Outstanding Intern Award.

Student winners: Third-year students David Franklin Craig of Asheville who received the Frank Lee Dameron Award and Natalie Lorraine Sanders of Durham who won the Heusner Pupil Award; second-year students Edward Hiltner Bertram III of Char-

lotte, who won the Deborah C. Leary Award, Donald Campbell Whiteside of Charlotte, second-place award for excellence in the student research paper program and Marcus Eugene Carr Jr. of Greensboro, the William DeB MacNider Award; first-year student Charles Barnett Nemeroff of New York City, third-place award for excellence in the student research paper program.

\* \* \*

Dr. William A. Richey, chief resident of the department of radiology at North Carolina Memorial Hospital, was elected in May as chairman of the American Association of Academic Chief Residents in Radiology.

\* \* \*

Dr. Joseph S. Pagano, professor of medicine and bacteriology and immunology and director of the Cancer Research Center, presented "Epstein-Barr Virus Infection of Epithelial Cells and Lymphocytes" and Dr. Arthur H. Lockwood, assistant professor of anatomy, presented "Biological Regulation of Microtubule Assembly and Function" at the ICN/UCLA Symposium on Cell Reproduction in Keystone, Colo.

\* \* \*

Dr. W. Ray Gammon, assistant professor of dermatology, presented "Immunofluorescence and the

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pleasures in a man's life . . . **DAKS®**."

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Diagnosis of Systemic and Skin Diseases" at the Durham County General Hospital.

\* \* \*

Dr. Clayton E. Wheeler Jr., chairman of dermatology and Drs. Robert A. Briggaman and W. Mitchell Sams Jr., professors of dermatology, attended the annual meeting of the American Dermatological Association in West Palm Beach, Fla. Sams gave a report on the activities of the Society for Investigative Dermatology, reviewed the "Immune Mechanisms in Urticaria" and attended a meeting of the editorial board of the *Archives of Dermatology*. Dr. Sams also attended a meeting in St. Louis of a task force to advise the National Institute of Arthritis, Metabolism and Digestive Diseases on "Priorities and Needs for Research in Dermatology." Dr. Wheeler was among those invited to evaluate the graduate training program of the department of dermatology at the University of Minnesota, which he visited recently. He also attended the spring meeting of the American Board of Medical Specialties in Chicago as a representative of the American Board of Dermatology. Dr. Briggaman presented "Epidermal-Dermal Junction" and "Blistering Diseases of Childhood" to the department of dermatology of Brown University and participated in teaching rounds with the faculty and residents.

\* \* \*

Dr. George Johnson Jr., professor and chief of vascular surgery, presented "The Surgical Treatment of Esophageal Varices" and "The Red Cell and the Surgeon" at the University of South Carolina at Charleston, where he was visiting professor for post-graduate courses in April.

\* \* \*

Jo Ann Flair, coordinator of the Patient Education Center, presented "Patient Education — The North Carolina Experience" at the annual meeting of the Iowa Hospital Association in Des Moines.

\* \* \*

Dr. William G. Thomas, associate professor of surgery, otolaryngology and audiology and director of the Hearing and Speech Center, has been appointed by the N.C. Department of Labor to serve on the Advisory Council of the Occupational Safety and Health Association for 1978-1980.

\* \* \*

Dr. Michael C. Magee, chief resident in urology, presented "Mesonephric Duct Induced Mullerian Duplication" at the Southeastern Section of the American Urology Association in Louisville, Kentucky. The paper included a new classification of embryologic abnormalities of the genito-urinary and reproductive systems.

\* \* \*

Dr. Carl W. Gottschalk, Kenan professor of medicine and physiology and one of the world's foremost

kidney researchers, is the 1978 recipient of the O. Max Gardner Award. The award is the only statewide honor given by the board of governors of the University of North Carolina and is presented annually to a faculty member of the 16-campus UNC system who, during the current scholastic year, has made the greatest contribution to mankind. Gottschalk has been influential in national planning for dialysis and kidney transplantation treatment of patients with kidney disease. He is also a Career Investigator of the American Heart Association.

\* \* \*

Dr. Fred W. Ellis, professor of pharmacology, participated in the medical-scientific meetings of the National Council on Alcoholism in St. Louis. Ellis was co-chairman of a workshop session on experimental studies of the fetal alcohol syndrome. He presented a paper on morphologic abnormalities in the beagle model of this syndrome and was a panel member for discussion of the topic. Ellis and Dr. James R. Pick, director of the division of laboratory animal medicine, are co-investigators in studies of alcohol effects on fetal development.

\* \* \*

Dr. Herbert J. Proctor, associate professor of surgery, presented "Central Nervous System Dysfunction After Hypoxia and Hypotension" at the Pre-Congress Program of the European Society for Surgical Research in Copenhagen and Stockholm.

\* \* \*

Dr. Jack B. Peacock, assistant professor of surgery and director of the Military Assistance to Safety and Traffic program, was presented the Order of the Longleaf Pine award by the governor while attending a celebration at Ft. Bragg of the 500th MAST mission by the 57th Medical Detachment.

\* \* \*

C. N. Stover, assistant dean for business affairs, chaired a panel on excesses in federal regulations and paperwork at a meeting of the Association of American Medical Colleges' Southern Section, Group on Business Affairs, in San Antonio.

\* \* \*

Mary M. Horres, associate director of the Health Sciences Library, is co-chairing the program committee for the North Carolina Governor's Conference on Libraries and Information Services to be held in October.

\* \* \*

Samuel Hitt, director of the Health Sciences Library, testified before the House Subcommittee on Health and the Environment on behalf of the renewal of the Medical Library Assistance Act.

\* \* \*

Dr. John T. Sessions, professor of medicine, was a member of the guest faculty for "Update Gastroen-



erology — 1978." the University of Mississippi's first three-day gastroenterology course for the practicing physicians. Sessions spoke on "Clinical Pathophysiologic Correlates: Gastrin, Acid, Anacids"; "Duodenal Drainage"; "Gallstones and Chenodeoxycholic Acid" and "Current Concepts of Therapy: Inflammatory Bowel Disease." He served on panels discussing "Who Should Have Surgical Approach to Reflux Esophagitis?"; "What is Proper Therapy for Duodenal Ulcer Today?"; "Peritoneoscopy, Pancreatic Biopsy, Transhepatic Cholangiograms" and "Is Endoscopy Being Over-Utilized? When, What, Who, How?"

\* \* \*

Dr. Mary Ellen Jones has been appointed professor and chairman of the Department of Biochemistry and Nutrition. She comes to Chapel Hill from the School of Medicine at the University of Southern California where she has been a professor of biochemistry since 1971. Before that she was an associate professor and then professor in the UNC-CH departments of biochemistry and zoology for five years. After receiving her B.S. degree from the University of Chicago and her Ph.D. degree from Yale University, she taught in the graduate Department of Biochemistry at Brandeis University.

\* \* \*

A portrait of the late Dr. Ernest H. Wood has been presented to the Department of Radiology. Dr. Wood served as professor of radiology and the department's first chairman from 1952 to 1965. The portrait was presented by the E. H. Wood Radiological Society, comprised of residents who trained at UNC-CH while Wood was chairman. It will hang in the departmental library, which will be named for Wood.

\* \* \*

Dr. Frank T. Stritter, associate professor in the medical school's office of medical studies and in the School of Education, has been elected chairman of the Southern Regional Group on Medical Education, a component of the Association of Medical Colleges.

#### News Notes from the—

### DUKE UNIVERSITY MEDICAL CENTER

One of the world's most highly respected eye surgeons has accepted an appointment as chairman of the Department of Ophthalmology here.

Dr. Robert Machemer, currently associate professor of ophthalmology at the University of Miami's Bascom Palmer Eye Institute, will succeed Dr. Joseph A. C. Wadsworth in the position Sept. 1.

Wadsworth, who founded the Duke Eye Center, will continue his practice and teaching responsibilities at Duke. In March he turned 65, the mandatory age at

which department heads give up administrative duties.

Machemer, 45, is a native of Muenster, Germany. He received his medical education at the universities of Muenster and Freiberg and at the University of Vienna in Austria.

After serving an internship at Rodalben Hospital in 1961, he spent a year as a fellow in general pathology at Freiberg and then completed his residency in ophthalmology at the eye clinic of the University of Goettingen in 1965.

The surgeon came to the United States in 1966 as a research fellow at the Bascom Palmer Eye Institute and was named to the University of Miami School of Medicine faculty in 1968.

Machemer and his wife, Dr. Christel Machemer, a psychiatrist, have a 15-year-old daughter named Ruth.

\* \* \*

Directors of nursing services have been appointed for what will be known as the north division and the south division of Duke Hospital when its new hospital opens next year.

They are Mary Ann Peter, who will direct nursing in the north division, and Evelyn B. Wicker, who will be responsible for the hospital's south division. Both are registered nurses who also have master's degrees.

Mrs. Peter, wife of Dr. Robert H. (Jess) Peter, codirector of Duke's Cardiovascular Laboratory, moves to her new post from directorship of Duke's Quality Assurance Program in Nursing. Mrs. Wicker has been supervisor of Duke's Ambulatory Nursing Service.

Duke's north division will include the 39-bed Eye Center, which opened in 1973, and the new 616-bed Duke Hospital North, which will admit its first patients about a year from now. In addition to ophthalmology patients at the Eye Center, Duke North will contain inpatient services for medicine, surgery and pediatrics. The emergency department also will be located there.

The south division will include the present hospital, 333 beds of which will be retained for inpatients in obstetrics-gynecology, psychiatry and inpatient rehabilitation. Duke South will house ambulatory services. It also will include a 20-bed inpatient unit in the Edwin A. Morris Clinical Cancer Research Building.

Inpatient areas in the four units — Duke North, Duke South, the Eye Center and the Morris Building — will be known collectively as Duke University Hospital and will have 1,008 beds, an increase of about 100 beds over the present capacity.

\* \* \*

Dr. Kenneth L. Pickrell, professor of plastic, maxillofacial and oral surgery, has been named to the Society of Scholars at The Johns Hopkins University.

The society honors former postdoctoral fellows at Johns Hopkins who have gained marked distinction in their fields of academic or professional interest.

Pickrell received his M.D. from Hopkins in 1935. He completed postdoctoral training and served on the

hospital staff there until 1944 when he was appointed professor and chief of the Division of Plastic, Maxillofacial and Oral Surgery here. He gave up administrative responsibilities as chief of his division in 1975 but continues in practice at Duke.

\* \* \*

The National Institute of General Medical Sciences has awarded a \$128,000 grant to a Duke scientist who hopes to help physicians be more accurate in prescribing medications for their older patients.

Dr. Gerald M. Rosen, associate professor of pharmacology, will use the grant to support a three-year study of drug metabolism.

\* \* \*

Five Duke physicians have been honored by the American College of Obstetricians and Gynecologists (ACOG).

First prize in the organization's annual clinical and basic science competition was awarded to Drs. Marcos J. Pupkin, David A. Nagey, David W. Schomberg and M. Carlyle Crenshaw Jr.

One of two academic training fellowships awarded for the year 1978-79 by the ACOG and the Ortho Pharmaceutical Corp. of Ruritan, N.J., was given to Dr. Arnold Grandis, chief resident in obstetrics and gynecology.

\* \* \*

A Duke professor has received the highest award of the German Medical Association.

Dr. Siegfried Heyden, professor of community and family medicine, was honored for the two-year cancer education and screening program he directed at 19 textile plants of the Cannon Mills Co. The program concluded last fall. Twenty-four cases of cancer were detected, 18 in early stages.

In 1975, he won the association's Hufeland Prize for his health education efforts in Swiss schools and department stores. He was awarded the association's silver medal in the same year for studies of heart disease and cancer epidemiology.

\* \* \*

On July 1, Dr. Calvin R. Peters, assistant professor of plastic surgery became program director in the Department of Plastic Surgery at the Cleveland (Ohio) Clinic.

\* \* \*

Promotions to associate professor:

Drs. Peter Cresswell and Jeffrey R. Dawson, immunology; Dr. Gerald Rosen, pharmacology; Dr. James H. Carter, psychiatry; Dr. Lazaro Mandel, physiology.

Promotions to assistant professor:

Dr. Harold A. Ziesat Jr., medical psychology; and Drs. Judith C. Andersen, Thomas M. Bashore, David S. Caldwell, John R. Rice, James K. Roche and Ali Soroush, medicine.

Appointments to assistant professor:

Dr. Stephen H. Ladwig (M.D. Northwestern '72), radiology; Dr. Edmund C. Blach (M.D. U. of Capetown '46), anesthesiology; Dr. Gary N. Foulks (M.D. Columbia '70), ophthalmology; Dr. Edward Ganz (M.D. Chicago '67), surgery.

News Notes from the—

## EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

Researchers at the ECU School of Medicine and Pitt County Memorial Hospital are participating in a collaborative study examining the levels of pollutants to which bottle and breast-fed babies are exposed. The project is funded by a \$54,946 grant to the ECU Department of Pediatrics from the National Institute of Environmental Health Sciences, Research Triangle Park. Similar grants have been awarded to Wake Medical Center and Durham General Hospital.

The study will use statistics gathered from 200 breast-fed and 200 bottle-fed babies, according to Dr. Jon B. Tingelstad, chairman of the pediatrics department and local principal investigator. Participants will be volunteers from the community contacted through local physicians' offices and Lamaze classes.

The infant feeding project is designed to measure the levels of polychlorinated biphenyls in milk fed to infants. Examinations and tests will be used to see if there is a pattern between exposure to PCBs, a by-product of plastic production, and infant development and health.

Samples of the mother's blood, cord blood and placental tissue will be used to measure the level of pollutants the baby was exposed to during pregnancy. The infant will then be monitored for the first six months of life to examine the effect of the substance on the baby's development.

\* \* \*

ECU's continuing medical education program has received accreditation from the Liaison Committee on Continuing Medical Education. The accreditation will permit the medical school to grant credits to physicians participating in the school's continuing education programs. Dr. F. M. Simmons Patterson, assistant dean for continuing medical education, will administer the program.

Prior to receiving the accreditation, the School of Medicine offered credits for programs co-sponsored with the Eastern Area Health Education Center at the University of North Carolina School of Medicine.

The LCCME granted the accreditation on a provisional basis for two years.

\* \* \*

Dr. Donald R. Hoffman, associate professor of pathology, conducted postgraduate courses in forensic pathology.

lergy at five hospitals and medical schools during June. The one-day sessions were sponsored by Georgetown University, Washington, D.C.; Tufts University and St. Elizabeth's Hospital, Boston, Mass.; the Los Angeles Society of Allergy and Clinical Immunology, Anaheim, Calif.; the Cleveland Allergy Society and Mt. Sinai Hospital, Cleveland, Ohio; and Henry Ford Hospital, Detroit, Mich.

\* \* \*

Twenty-one students seeking health related careers enrolled in ECU's first summer program for future doctors, nurses and allied health professionals. Sponsored by the medical school's Center for Student Opportunities, the eight-week program for minority and disadvantaged students stressed the basic sciences and reading and learning skills.

Thomas L. Beatty, Jr. of Charlotte has received the Huffman Award for demonstrating the highest level of academic achievement and personal stature in the first-year class at the School of Medicine. Established in 1972 in honor of Mr. and Mrs. Charles F. Huffman, the award was the first to be presented at the medical school.

\* \* \*

Dr. Bryon T. Burlingham, professor and chairman of the Department of Microbiology, presented "The Physical Characterization of Incomplete Coxsackie Virus B4" at a meeting of the American Society for Microbiology held in Las Vegas. Dr. James E. Akers, instructor, presented "Physical Properties of Coxsackie Virus B4." Their research is part of the School of Medicine's continuing study of the mechanisms of pathogenesis of viral myocarditis.

## *Month in Washington*

The Congress recessed for the Fourth of July holiday without the House Commerce Committee taking final action on the administration's proposed hospital cost containment legislation. May and June saw bitter struggles within the committee, including one in which the White House agreed to back a new \$75 million Veterans Administration hospital in Camden, N.J., after Rep. James Florio (D-N.J.) decided to back the cost containment bill.

The two month struggle has pitted the Carter Administration's attempt to place an artificial cap on hospital revenues — an imposition of controls on just one part of the economy — against a voluntary effort group (VE) comprised of the American Medical Association, the American Hospital Association and the Federation of American Hospitals.

\* \* \*

The American Medical Association has supported the overall goals of the wide-ranging disease prevention-health promotion bill introduced by Sen. Edward Kennedy (D-Mass.).

"Basic to success must be a major and continuing effort to educate the American people in healthful lifestyles and the importance of preventive medicine," testified Lowell H. Steen, M.D., a member of the AMA Board of Trustees. "Because results of such activities will not be visible overnight, we recommend a long-term commitment to these endeavors," said Dr. Steen.

The bill provides a new program of federal formula grants to states to assist them in meeting the costs of planning and providing health services. These state programs would be directed at reducing the five leading causes of mortality within the state through systems of early detection, screening and prevention. A state could also receive formula funds for programs designed to reduce the five leading causes of morbidity within the state.

Special project grants would also be available for: (1) treatment of hypertension; (2) immunization of children; (3) community fluoridation programs; (4) prevention of illnesses caused by environmental factors; (5) prevention of rodent-borne diseases; (6) physical fitness activities; and (7) lead-based paint poisoning prevention.

Dr. Steen said the AMA is pleased that the states would have a major role in determining priorities for the disposition of funds. "We have long stressed the importance of state and local action in health matters and we are encouraged by this proposal."

The proposed level of funding might not be sufficient to reduce the rates of mortality or morbidity in a state effectively, Dr. Steen said. "It would indeed be unfortunate for Congress to develop a major disease prevention initiative, yet to fund it inadequately so that the effort might not get off the ground." He suggested that initially funds be concentrated on disease prevention programs.

Dr. Steen said programs such as those anticipated in



the bill could substantially improve health, but "we should not be deceived into believing that these programs are a cure-all. Basic to success must be a major and continuing effort to educate the American people in healthful lifestyles and the importance of preventive medicine."

\* \* \*

Immediately following the Supreme Court decision in the Bakke case, C. H. William Ruhe, M.D., AMA's Senior Vice-President, made these comments on behalf of the Association:

The Supreme Court ruling seems to permit medical schools to continue using race as one factor in determining admission criteria. We hope that medical schools will, therefore, continue to use those selective admissions programs designed to increase the numbers of minority students. It is only through such programs that we can hope to increase the numbers of minorities in the practice of medicine.

The American Medical Association has long been in support of programs designed to increase minority representation in medical schools and in the practice of medicine. This position was reaffirmed in St. Louis at the Association's Annual Meeting through acceptance of a manpower report of the AMA Council on Medical Education. The report addressed the issue

of "Black and Other Minority Group Physicians with the opening statement: "The inadequate representation of minority groups in the medical profession and in medical school enrollments remains of concern to the AMA."

\* \* \*

The House Ways and Means Health Subcommittee has approved the Clinical Laboratory Improvement Act.

The new provision would prohibit percentage contracts with hospital-based physicians unless the charges were "reasonable" in terms of what the hospital would have paid for such services if the physician had been employed by the hospital, and the cost of other "reasonable expenses" incurred by physician in performing the services. This provision would be applicable to clinical laboratories outside of a hospital.

The Health Subcommittee also approved language which provides that "if the Joint Commission on Accreditation of Hospitals imposes standards for hospital laboratories that are at least equivalent to the national standards, the Secretary of HEW (or the state in the case of a state with primary enforcement responsibility) could deem a laboratory in a JCAH accredited hospital to be in compliance with the national lab standards."



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The CLIA bill extending federal regulations over clinical labs has passed the Senate and the House Commerce Committee which sent it to Ways and Means. All the bills are similar. The physician office exemption in Senate was not mandatory. The House exemption is automatic for groups of five or fewer, or for any size group if tests are done by the physicians themselves.

\* \* \*

Rep. Paul G. Rogers, 57-year-old Florida Democrat whose name is often synonymous with health legislation on Capitol Hill, has decided to quit the House after 12 terms. Chairman of the House Interstate and Foreign Commerce Committee's Subcommittee on Health and Environment, Congressman Rogers has gained the reputation of a knowledgeable, tough but always fair, prime mover of health legislation in the House.

Facing no important opposition at home (parts of Howard and Palm Beach counties), Rogers said he merely wants to try "a change of career" and is "open to offers."

Candidates to succeed him include Reps. David Sterfield (D-Va.), Richardson Preyer (D-N.C.) and Ines Scheuer (D-N.Y.), ranking members of the subcommittee.

\* \* \*

The House approved a \$55 billion money bill for the Health, Education and Welfare Department, both more and less than the Administration requested. The confusion arose because the House added \$641 million to specific programs, but also voted a \$1 billion general chop that may prove meaningless. Another \$17 billion of HEW programs must go through the appropriations mill, since the House is deferring action on these programs until their extended authorizations are approved later this year.

An amendment denying federal funds for Medicaid abortion payments unless the mother's life is imperiled was adopted by the House ensuring still another controversial go-around with the Senate on the emotional issue.

The rather muddled budget situation saw HEW Secretary Joseph Califano writing letters to lawmakers deploring "meat ax" cuts on the one hand and threatening a Presidential veto for too fat a bill on the other.

The \$1 billion "out" in effect was a challenge to Califano's report earlier this year charging that fraud, waste and abuse is costing the department more than \$1 billion a year. If that's the case, the House was wrong, then at least \$1 billion ought to be saved

through cracking down on the waste. However, no specific program reductions were required, nor will any services apparently be cut.

Much of the increase over the Carter budget voted by the House was for health manpower and general education outlays, which the Administration wanted trimmed. The National Institutes of Health received \$305.7 million more than the budget figure.

Many of the health program appropriations were sought by the American Medical Association which had urged that key programs, especially in the health manpower and national health service corps areas, not be slashed.

Rep. Robert Giaimo, (D-Conn.), chairman of the House Budget Committee, recently told the AMA that "with a few notable exceptions, we adopted the same strategy you outlined . . . for funding health programs."

"With respect to programs which support health care services, training of health manpower and biomedical research, the committee recommended adding \$250 million to the President's budget request," said Giaimo. "This total is in line with your recommendations, with the exception of the health professions education program for which you suggest fairly sizeable increases."

The Budget Committee chairman also said in a letter to James Sammons, M.D., AMA Executive Vice President, that "I am pleased on the whole that the AMA recognizes the need to constrain the rising costs of health care programs and has joined with hospital associations to reduce the rate of increase in hospital costs."

\* \* \*

The F. Edward Hébert Naval Regional Medical Center in New Orleans is a \$22 million white elephant that should be abandoned by the Navy, reports the General Accounting Office. The Defense Department agrees with the findings.

The GAO, Congress' investigative agency, said the west-bank installation has a daily average patient load of 23, less than 10 percent of the 250-bed capacity. The potential for increasing the work load significantly "is virtually nonexistent," said GAO.

No blame was assessed by the GAO in its findings on the new installation that was dedicated in 1976 to Rep. F. Edward Hébert (D-La.), former chairman of the House Armed Services Committee.

Annual operating and payroll costs for the hospital amount to more than \$7 million. GAO suggested the facility be used by the state of Louisiana for a planned adolescent mental health care installation, or that it be leased to Westbank Medical Center, Limited, which operates a nearby for-profit hospital.

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**Indications and Usage:** For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

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The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings:** Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage:** Not recommended for infants less than two months of age.

**Urinary Tract Infections:** Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

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15-30	½ the usual regimen
Below 15	Use not recommended

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# NORTH CAROLINA

## *Medical Journal*

The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY □ □ □ September 1978, Vol. 39, No. 9

### IN THIS ISSUE:

**CURRENT CONCEPTS: Management of Lung Cancer:** Frederick Richards II, M.D., Hyman B. Muss, M.D., Douglas R. White, M.D., Carolyn Ferree, M.D., John Stuart, M.D., M. Robert Cooper, M.D., and Charles L. Spurr, M.D.

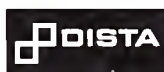
**The Late Results of Surgical Treatment of Lung Cancer:** Joseph W. Cook, M.D., Francis Robicsek, M.D., Harry K. Daugherty, M.D., Jay G. Selle, M.D., and Paul W. Sanger, M.D.

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**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or cimetidine Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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September 1978, Vol. 39, No. 9

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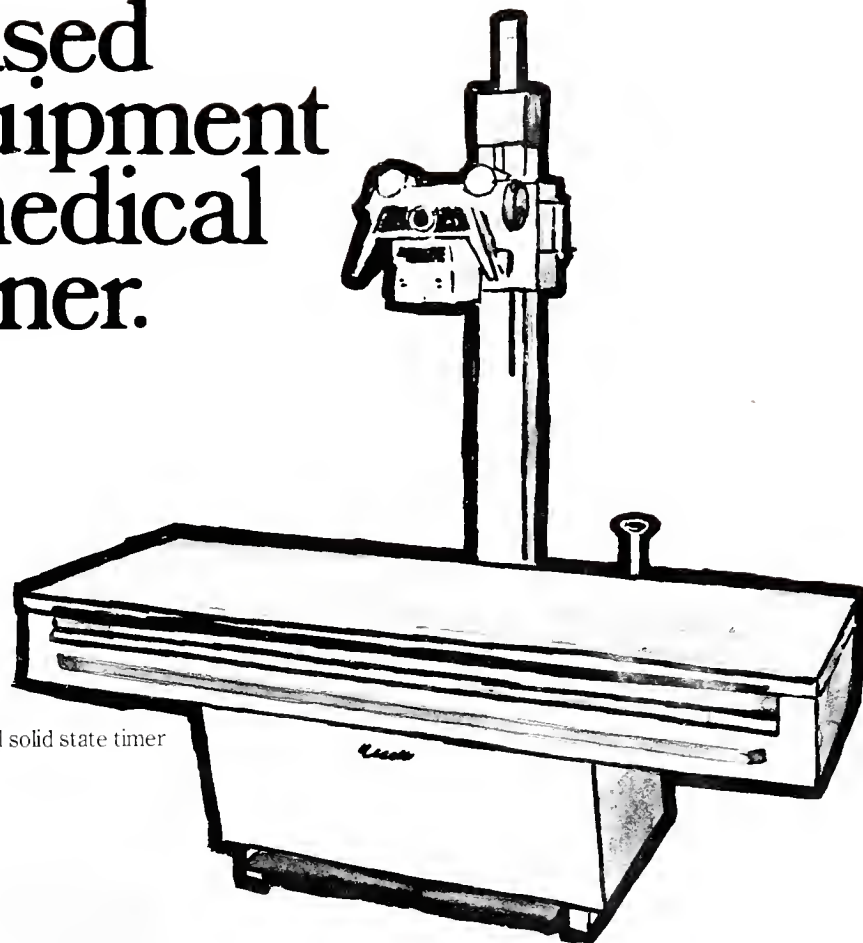
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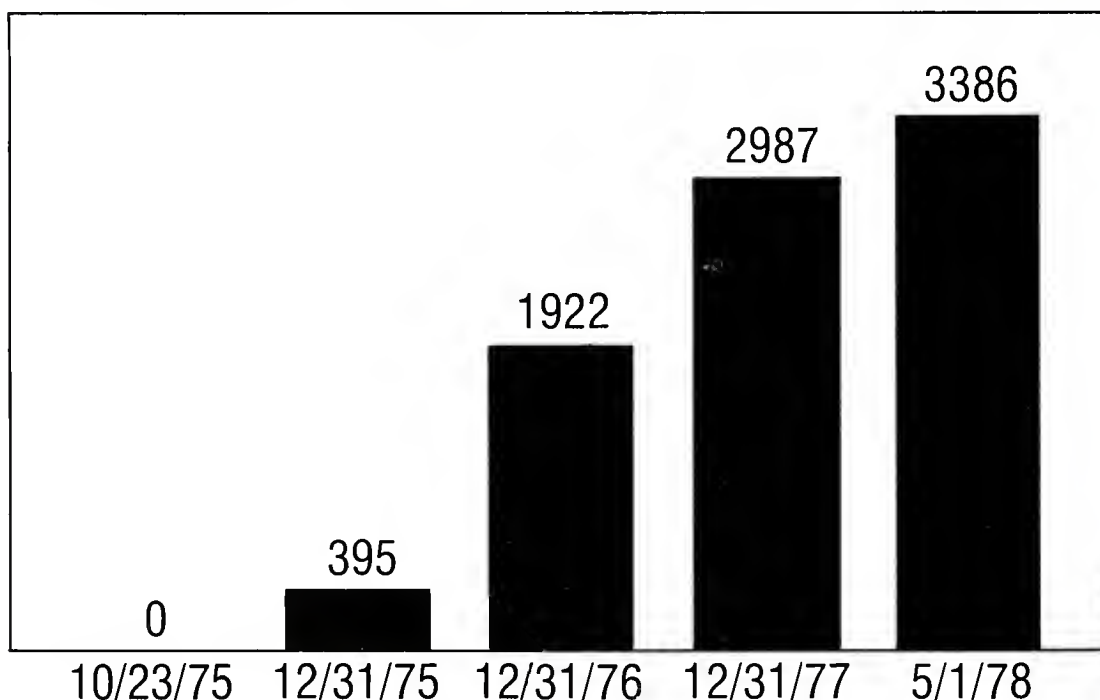
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Final classification of the less-than-effective indications requires further investigation.

**CONTRAINDICATIONS:** Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

**WARNINGS:** Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

**Usage in Pregnancy:** Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical

steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

**PRECAUTIONS:** Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not promptly discontinued the preparation until adequate control by other means is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken if irritation develops, discontinue the product and institute appropriate therapy.

**ADVERSE REACTIONS:** Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

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For full prescribing information, consult package insert.

**HOW SUPPLIED:** Available in 15, 30, and 60 g. tubes. It is also available in jars of 120 g. (4 oz.) for hospital or institutional use only.

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**CONTRAINDICATION:** Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

### PRECAUTIONS:

**General**—If irritation develops, dis-

continue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.

**Usage in Pregnancy**—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been

associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients in large amounts, or for prolonged periods of time.

**Occlusive Dressing Technique**—The use of occlusive dressing increases the percutaneous absorption of corticosteroids. For patients with extensive lesions it may be preferable to use a sequential approach, occluding portions of the body at a time. Keep the patient under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially on occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Discontinue use of the occlusive dressing and elevation of the body temperature.

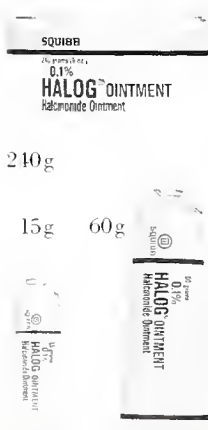
Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

**ADVERSE REACTIONS:** The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning sensation, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

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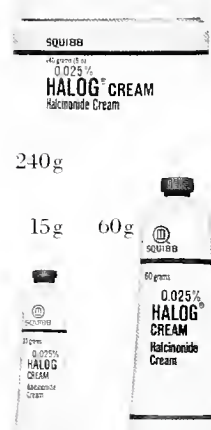
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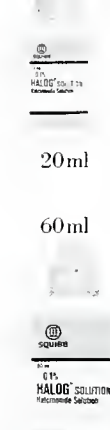
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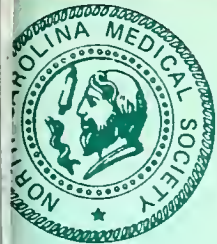


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## Hallog Solution 0.1% Halcinonide Solution 0.1%





# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

No. 4

September 1978

Our Society's membership in the AMA is increasing. We received a telegram from James H. Sammons, M.D., Executive Vice-President, AMA, stating: "Congratulations are in order for the tremendous support from the North Carolina Medical Society in being the ninth state to break the previous year's membership. As of August 4th our records show that you have 3,816 AMA dues paying members, exceeding the 1977 year end total of 3,809. It is certainly a notable accomplishment and our deepest appreciation for your support and participation". Many thanks to each of you who has joined the AMA this year, and I hope we can increase this number even more by the end of the year.

It is encouraging to see more physicians run for Federal and State Offices. Dr. Bill Roy, Topeka, Kansas, is seeking a seat in the U. S. Senate and Dr. Ross G. Pierpoint of Towson, Maryland, and Dr. Aris T. Allen, Annapolis, are both running for Governor of that state. In North Carolina Dr. Thomas Doyle Ghent, Charlotte, is a candidate for the North Carolina Senate, 22nd District, Mecklenburg and Cabarrus Counties. We certainly need more physicians in Federal and State positions. I hope that more doctors will consider running in the future, particularly for the North Carolina Senate and House seats. At present Dr. John Gamble, Lincolnton, and Dr. John W. Varner, Lexington, are the only physician members of the North Carolina Legislature.

Joseph J. Combs, M.D., Raleigh, has been appointed as representative of the Medical Society on the Governor's Coordinating Council on Aging.

I have received many letters from physicians across the state concerning the Prudential Insurance Company's Second Surgical Opinion Program. Many others of you have written the Prudential Insurance Company, and I appreciate receiving a copy of your letter. This will be on the agenda of the Executive Council meeting at Mid Pines on October 1st.

I believe that physicians in our state need to be more cost conscious, particularly, in our Medicaid Program. One area of concern is the long term care, especially in nursing homes, which is projected to spend \$100 million for the fiscal year 1978-79.

The ever mounting problem of allowing patients to remain in long term care beds longer than is medically necessary cannot continue to exist. Psycho-social factors alone cannot be used as rationale for allowing this to occur. Physicians are encouraged to assess properly the medical needs of a patient and provide each individual the opportunity to remain or return home as soon as medically possible.

In an effort to assist physicians, the North Carolina Medical Peer Review Foundation, Inc., offers the following synopsis to provide physicians with criteria for determining the appropriate levels of long term care for Title XIX patients.



Skilled Nursing provides nursing observation and assessment on a 24-hour basis. It is designed to meet the needs of patients who possess medical and/or special nursing problems which require continuous professional monitoring.

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The North Carolina Division of Archives and History suggested last Spring that the Medical Society purchase a World War II railroad ambulance train car which is now parked in Raleigh and rapidly deteriorating. The Executive Council approved the request and each physician received a letter requesting donations made to the North Carolina Medical Society Foundation, Inc., which would be tax deductible. The Society would purchase the car for \$4,000 and donate it to the Historic Spencer Shops (N. C. Transportation Museum) which is being planned for the Old Railroad Round House in Spencer, N.C. To date we have received \$1,150.00 towards this purchase, but we need the balance as soon as possible. The Division of Archives stated they would restore the car to its original condition if the Society could purchase it. I believe that this would be a fine thing for our Society to do for this Railroad Museum which in years to come will be a national tourist attraction for North Carolina. I encourage each of you to send a check immediately to the North Carolina Medical Society Foundation, Inc., P. O. Box 27167, Raleigh, N.C., for purchase of this last existing railroad ambulance car.

I certainly hope that each of you who are committee members will attend the Annual Committee Conclave at Mid Pines which will be held from September 27-30th. Our committee structure is designed for participation of individual physician members and your input through the committees is needed and is greatly appreciated. If you are not a member of a committee and desire any topic or proposal discussed, please write the chairman of that committee as listed in the last issue of the North Carolina Medical Journal. I am sure that the Chairman would be happy to place your item on the agenda.

Congratulations to John Glasson, M.D., of Durham who has been elected Vice-Chairman of the AMA Council on Medical Services, it was recently announced by the AMA Headquarters in Chicago. Dr. Glasson is a hardworking member of the AMA Council and will represent North Carolina capably in this new responsibility.

Sincerely,



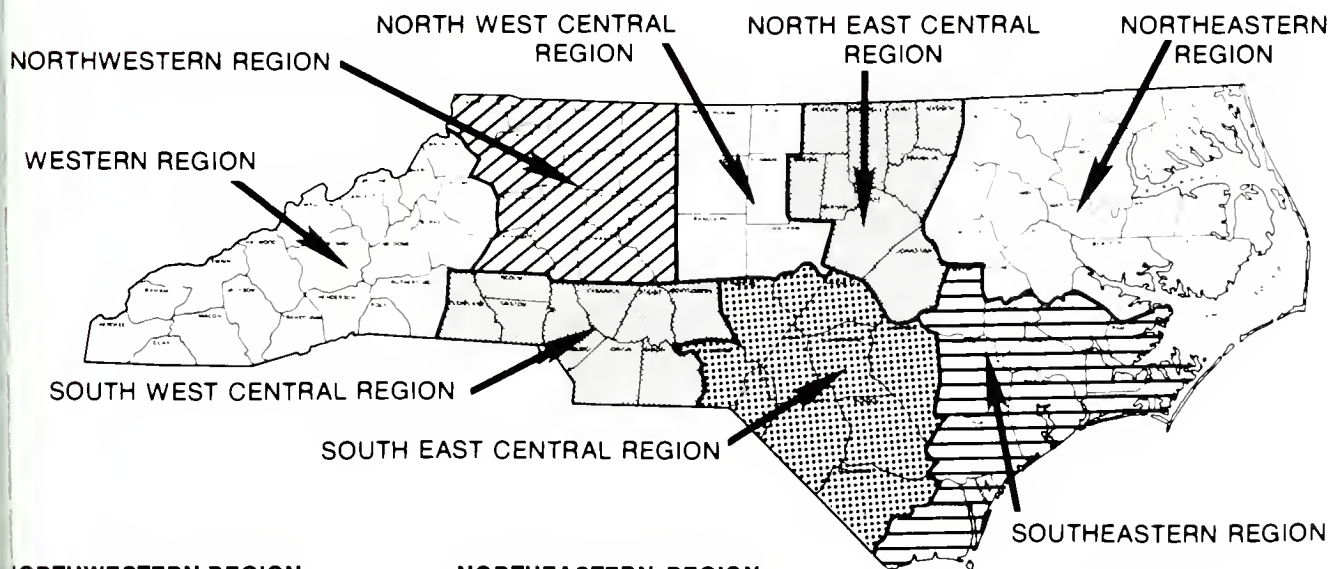
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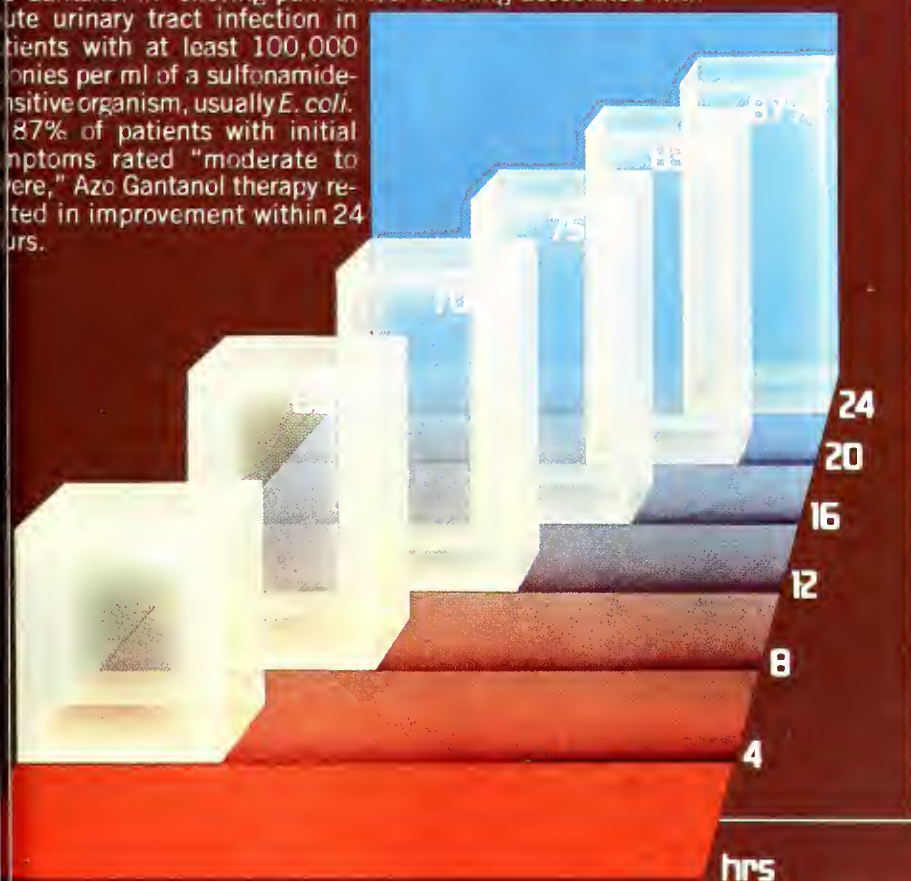
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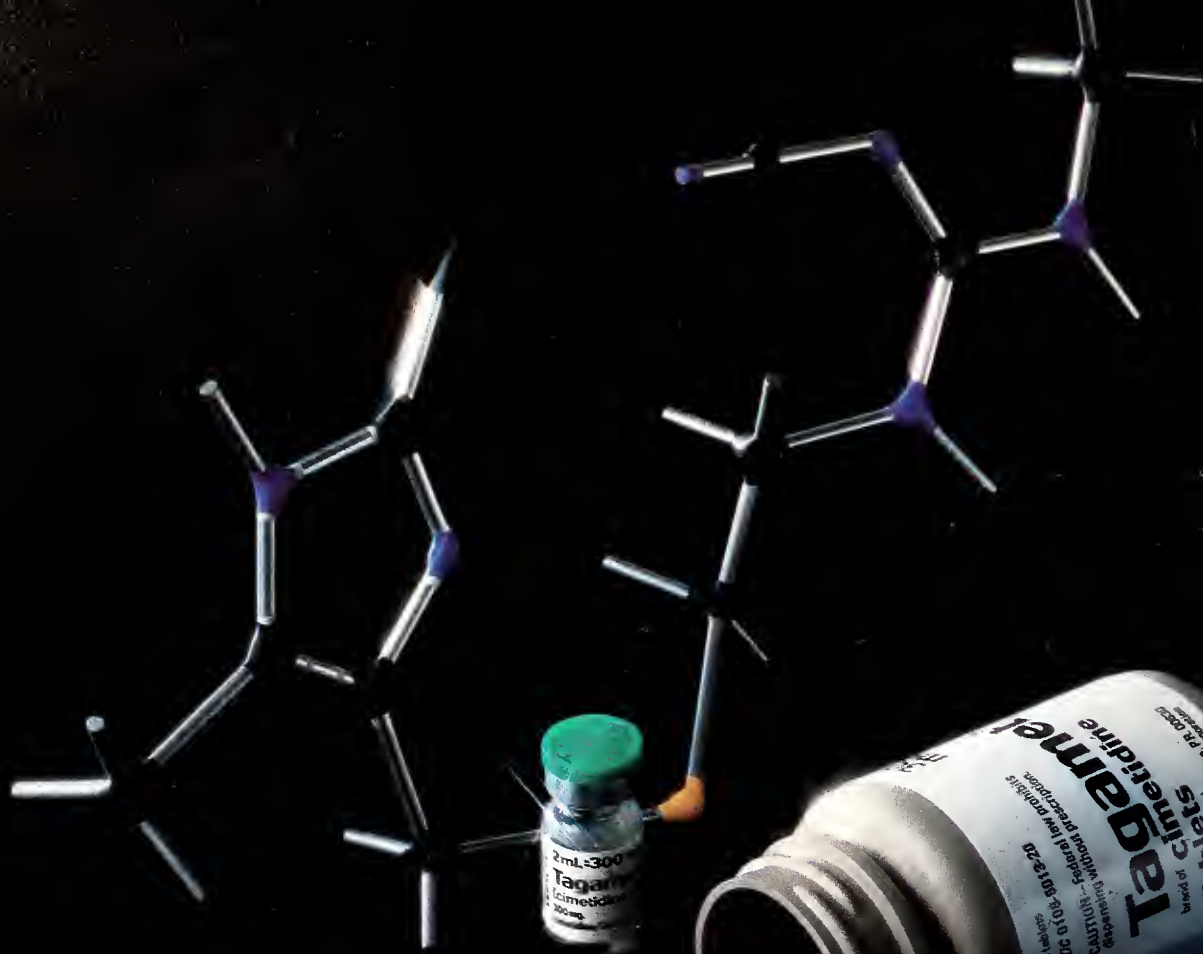
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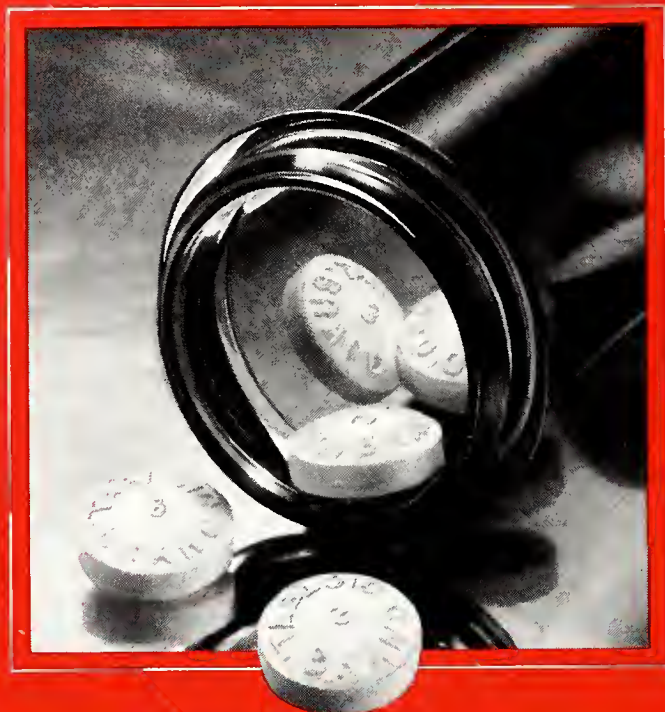


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# CURRENT CONCEPTS

## Management of Lung Cancer

Frederick Richards II, M.D., Hyman B. Muss, M.D.  
Douglas R. White, M.D., Carolyn Ferree, M.D.,  
John Stuart, M.D., M. Robert Cooper, M.D.,  
and Charles L. Spurr, M.D.

### INTRODUCTION

CARCINOMA of the lung, a relatively uncommon disease at the beginning of the 20th century, now ranks as the leading cause of death from cancer (89,000 in 1977). While its increasing incidence parallels the rise in cigarette smoking, other factors have been implicated: occupational and atmospheric pollutants such as metabolites of polycyclic hydrocarbons, aromatics, metallic iron and iron salts, arsenic, nickel and radioactive chemicals.<sup>1,2</sup> Pulmonary scars and fibrosis resulting from pulmonary infarcts, tuberculosis, chronic lung abscesses, chronic interstitial pulmonary disease and other necrotizing pulmonary disease have also been cited as predisposing factors. The 2,100 new cases of lung cancer in North Carolina in 1977 resulted in 1,900 deaths. The average survival time from diagnosis is six to nine months; fewer than 20% of patients live a year and about 5% survive for five years. The five-year survival rate among patients with limited disease who have undergone

a "curative resection" is about 35%. Progress in treating lung cancer has been limited, but the establishment of criteria for resectability and better understanding of the biological behavior of small-cell carcinoma have led to more rational therapy and better palliation.

It is now apparent that the death rate from bronchogenic carcinoma will not be appreciably decreased by serial cytological examination of sputum for malignant cells and screening chest X-ray.<sup>3</sup> Recent evidence indicating a link between susceptibility to bronchogenic carcinoma and higher levels of the membrane-bound enzyme aryl hydrocarbon hydroxylase (AHH) requires further investigation.<sup>4</sup>

The histology of the tumor, the anatomical extent of disease and the physical condition of the patient are the primary factors that determine treatment selection, which, in turn profoundly affects prognosis.<sup>5-8</sup> The Task Force on Cancer of the Lung created by the American Joint Committee for Cancer Staging and End Results Reporting has developed a staging system which correlates with the prognosis for all histological types except small-cell carcinoma.<sup>8</sup> The primary tumor, designated by the letter T, is classified by its size, location, extension and complications; involvement of

the regional lymph nodes is indicated by an appropriate category of N; the presence or absence of distant metastases is indicated by an appropriate category of M. This classification (TNM) is useful in planning and evaluating treatment. A brochure may be obtained from the Executive Secretary, American Joint Committee for Cancer Staging, 55 E. Erie Street, Chicago, Illinois 60611.

### CLINICAL PRESENTATION AND PROGNOSIS

Symptoms of lung cancer depend on the location and size of the primary tumor and the metastases to regional or distant sites (Tables I and II).<sup>9</sup> Fewer than 10% of lung cancers are discovered in an asymptomatic stage by routine roentographic examination. The first symptom is frequently a cough, usually productive and often associated with hemoptysis and/or chest pain. Weight loss and dyspnea are frequent; anorexia, hoarseness and pain from bone metastases occur less often. Feinstein, who has shown that prognosis in lung cancer is directly related to clinical symptoms, has developed a clinical symptomatic staging system.<sup>10</sup> Those who survive longest are the patients who were asymptomatic at presentation; the next longest are

From the Oncology Research Center of the Bowman Gray School of Medicine,  
10 S. Hawthorne Road  
Fayetteville, N. C. 27103

This work was supported in part by National Institutes of Health Grants CA-12197 and T-12-8037 and CA-3927

Reprint requests to Dr. Richards



**TABLE I: CLINICAL SYMPTOMS OF LUNG CANCER**

Bronchopulmonary	Extrapulmonary Intrathoracic	Extrathoracic Metastatic
Cough, often productive	Hoarseness	Neurologic Symptoms
Hemoptysis	Superior vena caval syndrome	Bone pain
Chest pain	Horner's syndrome	Weight loss
Wheezing, dyspnea, stridor	Dysphagia	Weakness, anorexia, lassitude, malaise
Febrile respiratory symptoms	Pleural effusion	Jaundice
	Pericarditis	Ascites
		Abdominal, neck, sub- cutaneous mass

those who have symptoms referable to the primary tumor for longer than six months.

Clinical features typically associated with histology are presented in Table III. The difference among the histological types is reflected in the etiology of disease, the mode of symptomatic presentation, the clinical course, the pattern of metastatic spread and the response to therapy. A tissue diagnosis is essential, as clinical behavior is correlated to histology.<sup>6</sup> Sputum cytology, particularly in well-differentiated epidermoid or adenocarcinoma tumors, or in small-cell undifferentiated (oat cell) carcinomas will often suffice.<sup>11</sup> In tumors which are less well-differentiated, biopsy material must be obtained for proper classification.<sup>12</sup>

Surgery is the treatment of choice when possible except in oat cell carcinoma.<sup>13</sup> The five-year survival of patients with resectable tumor is about 35%; unfortunately, 50% to 75% have non-resectable disease when first seen. Of those operated on, 50% are found to be unresectable and a third of the remaining patients undergoing "curative resection" will be found to have persistent local tumor or distant metastases within one month of surgery. Preoperative evaluation,

therefore, should identify patients who have anatomically resectable tumors and who are able to tolerate the physiological impairment resulting from pulmonary resection. An exploratory thoracotomy or a palliative resection that leaves tumor behind is rarely of benefit to the patient and is associated with appreciable mortality and morbidity. Some guidelines for selection of patients for resectability are given in Table IV. Transcervical mediastinoscopy, left parasternal exploration and angiography have proven to be the most accurate means of detecting mediastinal spread of bronchogenic carcinoma.<sup>14</sup> A patient's ability to tolerate a thoracotomy and excision of lung parenchyma can usually be accurately estimated by the history and physical examination (i.e., able to ascend two flights of stairs without significant dyspnea or tachycardia) supplemented by ventilatory function studies and measurements of arterial blood gases. Hypercapnia ( $\text{PaCO}_2 > 45$  mm Hg), hypoxia (an  $\text{PaO}_2 < 60$  mm Hg), maximum breathing capacity of  $< 50\%$  of predicted, or forced expiratory ventilation at 1 sec ( $\text{FEV}_1$ )  $< 1$  liter or vital capacity  $< 60\%$  of vital capacity usually preclude surgical resection.<sup>15</sup> More sophisticated studies

such as ventilation and perfusion scans and measurement of pulmonary arterial pressure may be helpful in a few patients.

## RADIOTHERAPY

The main indications for radiation therapy are palliation of distant metastases and management of unresectable or residual nodal disease confined to the chest.<sup>16</sup> The evidence that radiotherapy prolongs life is minimal; but radiotherapy frequently can control local disease and relieve symptoms of distant disease, thereby improving the quality of life and possibly prolonging survival. Radiation therapy can achieve local tumor response ( $> 50\%$  tumor regression on X-ray in 32% of patients with adenocarcinoma, 40% with epidermoid, 55% with large cell undifferentiated and 90% with small-cell tumors).<sup>17</sup> The chief obstacle lies in the disease itself, which is usually widespread before diagnosis. If there are widespread metastases and the primary tumor is relatively asymptomatic radiotherapy may be omitted. Radiotherapy is, however, essential in the treatment of superior vena caval obstruction and progressive pericardial effusion, in alleviating symptoms of brain metastases and cord compression, and in relieving the pain of bony metastases. It has resulted in better treatment of the superior sulcus tumor (Pancoast) when used with surgery<sup>18</sup> although tumors in other locations are not affected.

## CHEMOTHERAPY

Undifferentiated small-cell (oat cell) carcinoma of the lung is a relatively common disease (15,000 cases a year). At diagnosis, almost all have spread usually to liver

**TABLE II: PARANEOPlastic SYNDROMES OF LUNG CANCER**

Metabolic	Neuromuscular	Skeletal	Dermatologic	Vascular	Hematologic
Cushing's syndrome	Carcinomatous myopathy	Clubbing	Acanthosis nigricans	Migratory thrombophle- bitis	Anemia
Excessive anti- diuretic hormone	Peripheral neuropathy	Pulmonary hypertrophic osteopathro- athy	Scleroderma	Nonbacterial verruca	Fibrinolytic purpura
Carcinoid syndrome	Subacute cerebellar degen- eration		Dermatomyositis	endocarditis	Nonspecific leukocytosis
Hypercalcemia	Encephalomyelopathy		Tylosis	Arterial thrombosis	Polycythemia
Ectopic gonadotrophins			Other dermatoses		Thrombocytosis
Insulin-like activity					

rain, abdominal lymph nodes, adrenal glands, or bone marrow so that surgery is contraindicated. In untreated natural course, the median survival is 15 weeks for patients who present with limited disease and seven weeks for those with extensive disease. This tumor is characterized by very rapid growth and a short doubling time and, although quite sensitive to both radiation and chemotherapy, is prone to early recurrence. The overall response is in the range of 50%-80%, with 12%-25% being complete responses resulting in a significant prolongation of survival.<sup>19</sup> We have recently shown that prophylactic cranial irradiation may help prevent cerebral metastases; however, improved control of systemic disease will be necessary before survival is improved.<sup>20</sup> Although accompanied by significant morbidity, aggressive therapy consisting of irradiation of primary, mediastinal and supra-avicular areas and systemic

chemotherapy may result in some long-term remissions, with four patients in our series having lived longer than two years.<sup>20</sup> Median survival of 35-36 weeks with more than half of the patients surviving a year has been demonstrated when this combination is used.<sup>19,21</sup> Responses have been noted in patients with both extensive and limited disease. With these intensive programs, 10%-20% of patients require hospitalization for management of complications and a 2%-5% mortality is attributed to therapy.

The chemotherapeutic management of other histologic types of bronchogenic carcinoma remains challenging. Several agents (Table V) may lead to modest gains in median survival, but their use is usually associated with marrow toxicity, nausea and vomiting so that the net gain to the patient may be negligible.<sup>16</sup> One exception may be bronchio-alveolar carcinoma, which appears to be unusually sen-

sitive to 5-Fluorouracil.<sup>22</sup> In view of the toxicity of most agents, supportive care without chemotherapy is a reasonable alternative.<sup>23</sup> Early trials with combination chemotherapy alone<sup>24-29</sup> or with local irradiation<sup>30</sup> have shown promise. Chemotherapy is not currently indicated for elective treatment of the patient for whom resection is potentially curative.

### IMMUNOTHERAPY

Immunotherapy in all stages of lung cancer, generally with BCG, *C. parvum* and methanol extractable residue of BCG (MER), is under intensive investigation.<sup>31</sup> A single postoperative injection of intrapleural BCG has been reported to prolong survival significantly in a small series of patients with resected Stage I lung cancer.<sup>32</sup>

### MANAGEMENT OF SELECTED PROBLEMS

Epidural spinal cord compression should be suspected in any patient

TABLE III: CLINICAL FEATURES BY HISTOLOGICAL TYPE

	Epidermoid (Squamous Cell)	Adenocarcinoma	Small Cell (Oat Cell)	Large Cell (Undifferentiated)	Bronchial Adenoma
Percentage of all cases	35-60	15-20	35	5-15	5-10
1 year survival	27%	15%	1%	15%	86% (10 yrs.)
Median Doubling Time (Days)	103	187	33	92	
Association with Cigarette Smoking	Yes	Maybe	Yes	Yes	No
Parenchymal Abnormality	Central large mass or less commonly, small, ill-defined, peripheral mass	Peripheral small or less commonly large ill-defined mass. Bronchio-alveolar (multicentric, unilateral or bilateral nodules)	Central mass or less frequently peripheral mass.	Peripheral large ill-defined mass. Less common as central mass	Central, sharply margined mass.
Chest wall involvement	Common	Uncommon	Typical	Common	Rare
Intrathoracic or Extra-pulmonary involvement	Pleural effusion	Uncommon	Mediastinal widening	Occasional mediastinal mass	Uncommon
Bone Marrow involvement at diagnosis	3%	18%	45%	17%	Rare
Endocrine Hormone Production (Rare)	Parathyroid Hormone, Adrenocortico-tropic hormone (ACTH)	ACTH (Rare), Somatotropin, GH	ACTH, Melanocyte stimulating hormone, antidiuretic hormone (ADH), serotonin, calcitonin, renin-like material	Chorionic gonadotropin, somatotropin, FSH	Kallikrein, ACTH, CRF
Comments	Centrally located lesions-bronchial obstruction by intraluminal & peribronchial growth with pneumonia & abscess; Peripheral lesions-cavitation, Late metastases.	Early hematogenous & late lymphatic metastases. Rarely cavitation. Pleural metastases. Association with lung scars and chronic interstitial fibrosis	Metastasizes early & widely, Osteoblastic metastases. Rarely cavitates; Obstructive pneumonia and collapse. Grows by submucosal lymphatic extension.	Rapid growth, Early lymphatic and hematogenous metastases. Infrequently cavitation	Low grade malignancy. Infrequent metastases, except for atypical carcinoids & cystic adenoid. Bronchial obstruction. Hemoptysis



TABLE IV: EVALUATION FOR RESECTABILITY

Criteria of Unresectability	Evaluation Techniques
Central extension, phrenic nerve involvement	Bronchoscopy with or without mediastinoscopy, examination of diaphragm motion by fluoroscopy
Azygous vein obstruction, superior vena cava syndrome	Physical exam and/or venography
Pleural involvement	Chest X-ray; thoracentesis and cytological exam of any pleural fluid
Scalene node involvement	Physical exam with or without scalene made biopsy
Distant metastases	History and physical exam, liver function tests (liver scan if tests are abnormal, biopsy if scan is abnormal); brain scan; skeletal survey or bone scan.
Medical contraindications	General medical evaluation
Small-cell (oat cell) carcinoma #	Pulmonary function tests Bronchoscopy or mediastinoscopy with biopsy

# The  $\alpha$  100% incidence of metastases at the time small cell carcinoma is diagnosed contraindicates surgery in this type of lung cancer.

with back pain associated with sensory and/or motor impairment and/or loss of normal bladder or bowel function. Skeletal X-rays and/or scans frequently show vertebral involvement or destruction by tumor. Myelography is necessary to localize and determine the extent of epidural disease. Therapy may require either decompressive laminectomy with postoperative radiation therapy or radiation therapy alone, the choice depending on the radiosensitivity of the tumor and the acuteness with which the neurological deficit develops.<sup>33,34</sup>

Headache, focal weakness, behavioral or mental change, seizures, ataxia, or aphasia may be the presenting features of intracerebral metastases. While skull films are of little help, the brain scan and the computerized transaxial tomogram (CT scan) are valuable in diagnosis and have replaced invasive contrast procedures. Radiation therapy delivered to the whole brain is the mainstay of treatment of intracerebral metastases and adjuvant corticosteroid therapy is useful for relieving symptoms.<sup>35</sup>

Pleural effusion may be present initially or can occur late in the clinical course. Systemic chemotherapy or radiotherapy should be the initial treatment unless respiratory embarrassment is life-threatening. Initially, simple thoracentesis may provide adequate symptomatic relief; however, with recurrence, tube thoracotomy used alone or

with sclerosing agents (nitrogen mustard, cyclophosphamide, atabrine, tetracycline, or iodized talc) or radioactive colloids (gold, chromic phosphate, and yttrium) can be successful in 60%-90% of cases. Mediastinal radiotherapy may help control recurrent effusion if secondary to lymphatic obstruction rather than pleural seeding, the latter being the more common cause.

Radiotherapy is the treatment of choice for the superior vena cava syndrome which is often due to small cell carcinoma and rarely to epidermoid carcinoma.<sup>36</sup> Experience with chemotherapy is limited, but drugs in combination have produced good responses and objective remission.<sup>37</sup> Auxiliary measures include diuretics, nasal oxygen and elevation of the head of the bed.

Pleural mesotheliomas have been classified as solitary (localized) or diffuse, benign or malignant, and composed of epithelial or mesenchymal elements or an admixture of

the two.<sup>38</sup> The localized form is predominantly mesenchymal and is usually benign while the diffuse form generally behaves in a malignant fashion with a median survival of 14 months.<sup>39</sup> This locally invasive tumor usually has a mixed epithelial and fibrous pattern and rarely metastasizes. A 70% one year survival after a combination of surgery, radiotherapy and chemotherapy has been reported.<sup>39</sup> Because more than 65% of patients with this tumor have been exposed to asbestos, public health measures offer promise.<sup>40</sup>

Hypercalcemia complicates the course of lung cancer in from 10% to 30% of patients. This potentially fatal metabolic disturbance can produce serious central nervous system, renal and cardiac dysfunction; prompt treatment is essential and, at times, life-saving.<sup>41</sup> Cancer-related hypercalcemia is most commonly associated with bone metastases but may be caused by tumor products—iPTH (parathyroid hormone-like peptide), prostaglandins, OAF (osteoclast activating factor), vitamin D-like steroids, etc., and even by another primary malignancy. The possibility of coexistent benign causes such as primary hyperparathyroidism, vitamin D intoxication, milk-alkali syndrome, sarcoidosis, hyperthyroidism, and the use of thiazide diuretics should not be overlooked. The chloride-phosphate (Cl/PO<sub>4</sub>) ratio and serum iPTH correlate with serum calcium may be helpful but in our hands have not been useful in discriminating between primary and ectopic hyperparathyroidism. Hyperparathyroidism may coexist with cancer and should be considered if hypercalcemia persists with control of the cancer and there are no bone metastases.<sup>42</sup> Mild degrees of hypercalcemia (< 12 mg/dl) in the asymptomatic patient may require no more than close observation. The only specific treatment is eradication of tumor by surgery, chemotherapy, or radiation. General measures include fluid replacement with saline to facilitate calcium excretion. Large doses of furosemide intravenously can result in apprec

TABLE V: CHEMOTHERAPEUTIC AGENTS WITH ACTIVITY IN LUNG CANCER\*

Bleomycin sulfate (Blenoxane)
Cyclophosphamide (Cytoxan)
Doxorubicin HCL (Adriamycin)
Lomustine (CeeNU)
Mechlorethamine HCL (Mustargen)
Methotrexate
Procarbazine HCL (Matulane)
Vinblastine sulfate (Velban)
Vincristine sulfate (Oncovin)

\*Agents reported to induce objective response in > 15% cases.



le calcium diuresis but electrolyte abnormalities and acid-base imbalance are frequent unless potassium and chloride are adequately replaced. [Be extremely cautious when digitalization is necessary especially if hypokalemia and metabolic alkalosis are present.] Other measures include adrenal steroids, maintenance of ambulatory status, reducing calcium intake (to 40 mg/day) and oral neutral phosphate. Mithramycin or actinomycin-D can be used when the above measures fail or when life-threatening complications occur. Calcitonin, indomethacin and dialysis have occasionally been used successfully but should be reserved for those patients unresponsive to the above measures. Thiazides are contraindicated because they depress urinary excretion of calcium and may lead to elevated serum calcium.

A common problem is presented by the patient with an asymptomatic solitary pulmonary nodule. Radiological characteristics and clinical criteria of the lesion may suggest the correct diagnosis but tissue diagnosis is advisable in most cases (Table VI). Fewer than 10% of solitary pulmonary nodules are malignant but there is a greater risk of cancer if the patient is a male, smokes, is over 60 years of age and has an uncalcified lesion.<sup>43</sup> Sputum cytology and culture are usually negative although sputum obtained arising in the morning and after bronchoscopy may have better diagnostic yield. Skin tests may provide clues to etiology but should not be strongly relied upon and are not substitutes for an accurate tissue diagnosis. Cough and expectoration may be present and hemoptysis is occasionally a feature. From 90% to 95% of all solitary malignant pulmonary nodules are primary lung tumors. The solitary metastatic nodule usually occurs in the patient with a known extrapulmonary primary malignancy and only rarely as the first manifestation of an occult extrapulmonary primary tumor. Percutaneous needle biopsy or transbronchial biopsy will establish diagnosis in from 60% to 90% of patients. We recommend

TABLE VI: PATIENT WITH SOLITARY PULMONARY NODULE

	Benign <30 years	Malignant Increase frequency with increased age (ages 35-44, 15%, >80, 100%)
Calcific pattern	Central concentric lamellar, or diffuse homogenous calcification	None (fine stippled or small flecks of calcium may occur)
Doubling time (growth rate)	< 5 weeks or >2 years	between 5 weeks and 18 months
Smoking history	No	Yes
Size	small	large
Outline	smooth, sharp	ragged, irregular
Symptoms	No	Yes
Previous history of malignancy	No	Yes

preoperative mediastinoscopy for patients with solitary malignant nodules because 20% to 30%, though asymptomatic, will have positive mediastinal nodes. This procedure has little morbidity and almost no mortality. If the lesion is in the left lung and mediastinoscopy is negative, a left parasternal exploration is done. If mediastinal nodes are involved, the patient is incurable and thoracotomy is contraindicated. A few patients with well-differentiated squamous cell carcinoma confined to a low paratracheal lymph node may be cured by surgical excision.<sup>44</sup> The five-year survival rate in the patient with an asymptomatic, malignant solitary pulmonary nodule has been reported to be as high as 50%.<sup>45</sup>

### TUMOR MARKERS

Several tumor markers ["big" ACTH, carcinoembryonic antigen (CEA), polyamines] are being studied as routine screening tests for the diagnosis and treatment of lung cancer.<sup>46</sup> It appears that CEA is not of value and should not be used as a screening test.

### CONCLUSION

Although progress in the therapy of lung cancer, except for small-cell carcinoma, is minimal, assessment of candidates for curative surgery has improved through better diagnostic procedures. Curative radiotherapy is recommended for patients with resectable tumor in whom surgery is precluded for medical reasons. Radiotherapy is useful in symptomatic patients with either primary or metastatic disease. The palliative effect of chemotherapy is limited in lung cancer

other than small-cell carcinoma. Only through continued efforts to make the public appreciate the association of cigarette smoking with lung cancer and through control of environmental carcinogens can any significant gains be made in the control of this disease.

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And surely in my opinion, there cannot be a more base, and yet hurtful corruption in a Countrey, then is the vile use (or other abuse) of taking *Tobacco* in this Kingdome, which hath moved me, shortly to discover the abuses thereof in this following little Pamphlet.

If any thinke it a light Argument, so it is but a toy that is bestowed upon it. And since the Subject is but of Smoke, I thinke the fume of an idle braine, may serve for a sufficient battery against so fumous and feeble an enemy. If my grounds be found true, it is all I looke for; but if they cary the force of perswasion with them, it is all I can wish, and more than I can expect. My onely care is, that you, my deare Countrey-men, may rightly conceive even by this smallest trifle, of the sinceritie of my meaning in great matters, never to spare any paine that may tend to the procuring of your weale and prosperitie. — *A Counter-Blaste to Tobacco*, King James I, 1604.

# The Late Results of Surgical Treatment of Lung Cancer

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**ABSTRACT** The records of all patients with primary carcinoma of the lung admitted to Charlotte Memorial Hospital over a 23-year period were reviewed. Follow-up on 499 patients was available. The survival according to extent of disease, cell type and operative procedure was determined. The patients were grouped according to surgical stage and this was found to correlate well with survival. The five-year survival rate was 1.7% in Stage I, 10.9% in Stage II and 3.8% in Stage III. Adenocarcinoma was found to be the cell type associated with the best survival rates. Our study affirms the observation that early detection, before metastases occur, remains the key to satisfactory treatment of this disease.

It has been generally recognized that surgical removal offers the best, and in a great majority of cases, the only cure for carcinoma of the lung and that the optimal results are obtained if the disease is still well localized. Unfortunately, in the majority of patients, these conditions cannot be met.<sup>1-6</sup>

Since the first successful operation for pulmonary malignancy by

Graham and Singer in 1933,<sup>7</sup> tens of thousands of patients have undergone "curative" lung resections for carcinoma. Unfortunately, the late results of these operations are relatively poor and they did not improve in proportion to the general progress in thoracic surgery. Adding to the data concerning the surgical treatment of carcinoma of the lung, this study represents 23 years of experience in a private thoracic surgical group in a large teaching hospital.

## MATERIALS AND METHODS

The records of all patients (private and staff) with the diagnosis of primary carcinoma of the lung admitted to our service at Charlotte Memorial Hospital from 1950 through 1973 were reviewed. A total of 631 charts were available for study. An attempt was made to follow up every patient by obtaining death certificates and/or contacting referring physicians, families or the patients themselves, but we were able to obtain long-term follow-up information only on 499 (79%). That data forms the basis of this report.

All patients were "surgically" staged according to the methods established by the American Joint Committee on Stages and End Results Reporting (Table I). Histologic

confirmation was obtained for all lymph node metastases. Chest wall or mediastinal invasion was noted.

Survival figures and graphs were based on the life table method.<sup>8</sup> Deaths that occurred within 30 days of surgery were considered operative deaths and are included as such in all statistics.

## RESULTS

The total series consisted of 403 males and 96 females ranging in age from 29 to 91 with a mean age of 59.0 years. When first seen, 187 patients (37.4%) were considered unsuited for surgery because of tumor location, nodal involvement or distant metastases. Hence, 362 patients (62.6%) were considered potentially curable and underwent exploratory thoractomy. Only 153 patients (30.7%) had resection of their lesion. The median survival of this group was 2.7 years; 24.8% survived five years (Table II).

The overall operative mortality for 153 resected cases was 9.8%; for lobectomies 9.4% and for pneumonectomies 10.6%. The survival rate as it relates to the type of surgery is shown in Table II.

As expected, the 27.1% five-year survival rate for lobectomy was considerably higher than that for pneumonectomy (14.6%), reflecting the more limited and peripheral na-

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**TABLE I**  
**The Definition of Stages for Carcinoma of the Lung**

PRIMARY TUMORS	
T	No evidence of primary tumor
TX	Cytologically proven tumor without other evidence
T1	A tumor 3.0 cm or less in greatest diameter surrounded by lung or visceral pleura and not proximal to a lobar bronchus at bronchoscopy
T2	A tumor more than 3.0 cms in greatest diameter or any tumor involving visceral pleura or extending to the hilum. At bronchoscopy the proximal extent of tumor must be within a lobar bronchus or at least 2.0 cm distal to the carina. Any associated atelectasis or pneumonitis must involve less than an entire lung and there must be no pleural effusion.
T3	A tumor with direct extension into a structure adjacent to the lung or involving bronchus less than 2.0 cm distal to the carina, any tumor associated with atelectasis or pneumonitis or an entire lung or pleural effusion.
REGIONAL LYMPH NODES	
N0	No lymph nodes involved
N1	Metastases to peribronchial or ipsilateral hilar lymph nodes
N2	Metastases to mediastinal lymph nodes
DISTANT METASTASES	
M0	No distant metastases
M1	Distant metastasis such as scalene lymph node, contralateral lung, etc.
Stage I	T1 NO MO T1 N1 MO T2 NO MO
Stage II	T2 N1 MO
Stage III	T3 with any N or M N2 with any T or M M1 with any T or N

ture of these lesions (Figure 1).

Diagnostic thoracotomy, when tumor was unresectable, proved not to be an innocuous procedure. Of 159 patients who underwent thoracotomies without resection, the operative mortality rate was 7.5%. The 2.7% who survived for five years represents those who showed excellent response to radiation therapy and/or chemotherapy. Radiation therapy was routinely given for residual tumor unless it was contraindicated by the general condition of the patient or by the diffuse spread of disease. Approximately 20% of the "non-resectable" patients also received some form of chemotherapy.

## HISTOLOGY

The distribution of tumors by cell type was by and large similar to the other series with 60.1% being squamous cell, 15.0% adenocarcinoma, 15% large cell undifferentiated, 6.6% small cell undifferentiated and 3.2% bronchioalveolar. As can be seen in Table III, adenocarcinoma was associated with the highest median and five-year survival, reflecting the tendency of these tumors to occur peripherally. Figure 2 displays the survival rate relative to cell type. Of the patients who had surgical resections, those with adenocarcinoma again had a more favorable outlook (Table IV). As expected,

patients with small cell undifferentiated tumors had a uniformly poor outlook.

## STAGING

In 91 patients (18.2%) the disease was confined to the lung or hilar nodes (Stage I). Fifty-eight patients (11.6%) were in Stage II. The majority of patients (350 or 70.2%) had extension of tumor to the chest wall or distant metastases when initially seen (Stage III). Figure 3 shows the survival according to stage. There was no statistically significant difference between the survival of patients in Stage II and Stage III. The five-year and ten-year survival rate in Stage I was significantly different from both the other stages ( $P < 0.5$ ). The mean survival in Stage I was 3.2 years with Stage II 1.8 years and Stage III 0.9 years. Stage I had five-year and ten-year survivals of 32.7% and 14.5%. For patients in Stage II these figures dropped to 10.9% and 4.4% (Table IV).

The distribution of cell type within each stage was roughly the same as the total distribution with the notable exception of small cell undifferentiated. Only one patient of 33 with this cell type was free of demonstrable metastases at the time of diagnosis. Two patients were in Stage II and the remainder had distant metastases and were therefore in Stage III.

## DISCUSSION

In our largely private-practice setting, it might be expected that referrals would be made earlier and lead to more favorable prognosis for patients with carcinoma of the lung.<sup>2</sup> The overall resectability rate for cure of 30.7% contradicts this expectation. Lee in a recent review found the national average for localized disease to be about 20% with distant metastases present in 40% of patients when first diagnosed.<sup>4</sup> This latter figure coincides with our figure of 37.4% with distant metastases. Since cure of these patients depends upon surgical removal of a localized lesion, early diagnosis still remains the primary goal. The importance of early diagnosis is pointed out by the series of Steele, et al.,<sup>10</sup> who found a 95%

**TABLE II**  
**Postoperative Mortality and Survival Rates for Lung Cancer**

	N	30 Day Mortality	Mean Survival (Years)	5-Year Survival	10-Year Survival
Lobectomy	106 (69.3%)	9.4%	2.9	27.1%	12.0%
Pneumonectomy	47 (30.7%)	10.6%	2.1	14.6%	4.9%
Total Resections	153 (100%)	9.8%	2.7	24.8%	10.0%
Thoracotomy without Resection	159	7.5%	1.1	2.7%	2.7%

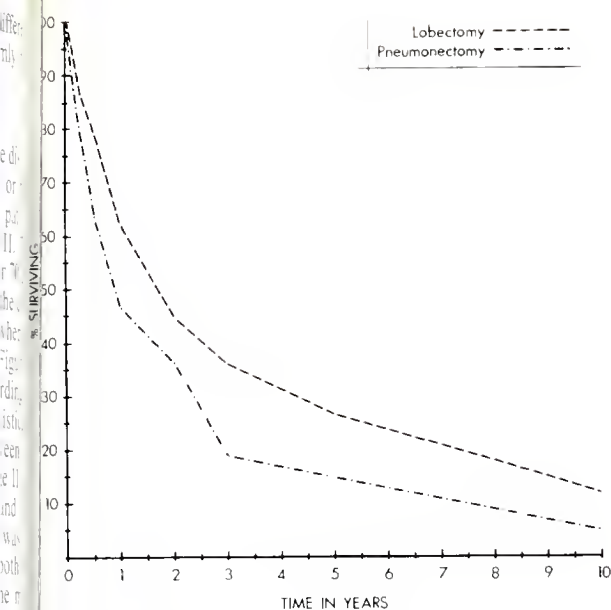


Fig. 1. Survival by type of surgical resection.

resectability rate and a 38.5% five-year survival in patients with asymptomatic pulmonary nodules. In this series, 62% of the patients underwent exploratory thoracotomy with 30.7% being resectable. The disparity between these figures results from several factors. First, it is our philosophy that since surgery is the only cure for the disease, it should be employed if even a remote chance of resectability exists. Hence, exploration is denied only in the face of biopsy-proven metastasis or spread and is rarely denied in roentgenographic evidence alone. Secondly, palliative resections are rarely performed. We agree with Paulson and others that extended pneumonectomy adds little to the treatment of the disease.<sup>3</sup> Therefore, we were very aggressive about giving the patients every chance for resection but tended to be conservative once spread to mediastinal nodes or other extension was demonstrated. The third factor influencing the high percentage of explorations without resection is that most of them were done before the general acceptance of mediastinoscopy. In recent years its use in selective cases has substantially increased the resectability rate by proving the presence of distal metastases and therefore sparing a sizable number of patients from unnecessary thoracotomies.

The cell type associated with the

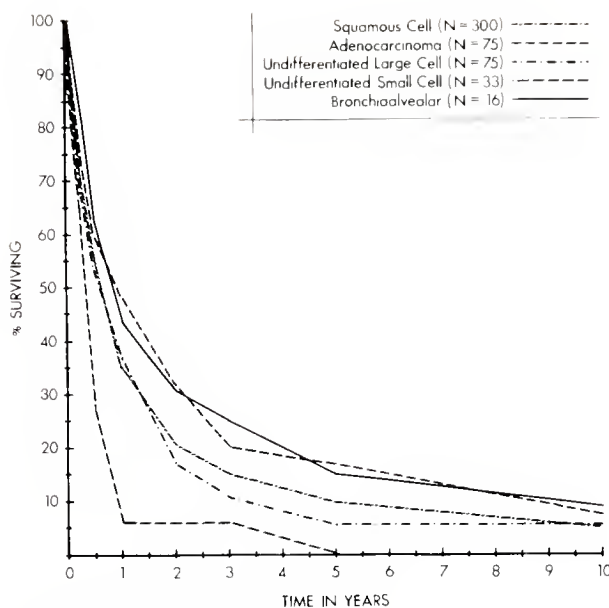


Fig. 2. Survival by histologic type.

TABLE III  
Overall Survival Rates for Carcinoma of the Lung  
According to Histologic Type

Cell Type	N	Mean Survival (Years)	5-Year Survival	10-Year Survival
Squamous	300 (60.1%)	1.4	9.9%	4.7%
Adenocarcinoma	75 (15.0%)	2.2	12.2%	6.7%
Large Cell Undifferentiated	75 (15.0%)	1.2	5.4%	5.4%
Small Cell Undifferentiated	33 (6.7%)	0.6	0	0
Bronchioalveolar	16 (3.2%)	1.8	17.9%	8.9%
	499 (100%)	1.4	10.0%	4.8%

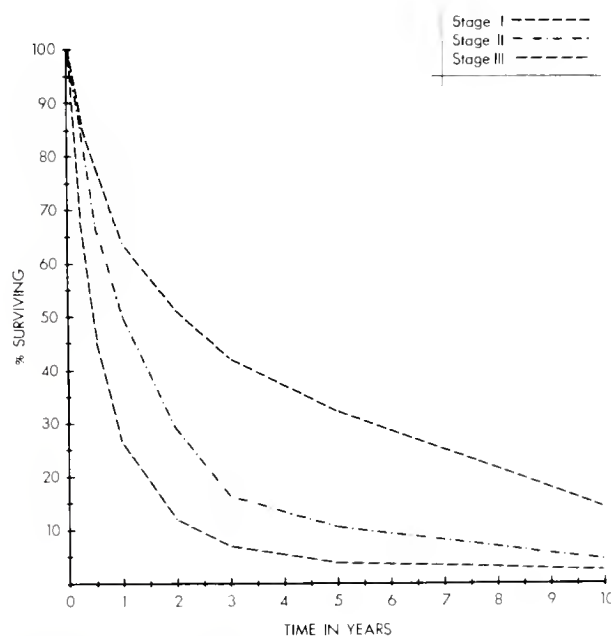


Fig. 3. Survival by stages.

**TABLE IV**  
**Survival Rates for Carcinoma of the Lung**  
**According to Stage, Histologic Type and Surgical Resection**

Cell Type	Stage I		Stage II		Stage III	
	5-Year Survival	10-Year Survival	5-Year Survival	10-Year Survival	5-Year Survival	10-Year Survival
Squamous	30.1%	13.2%	12.7%	4.2%	3.7%	2.6%
Adenocarcinoma	50.1%	20.6%	22.2%	11.1%	3.7%	0%
Large Cell	25.1%	25.1%	0%	0%	3.8%	3.8%
Undifferentiated						
Small Cell	0%	0%	0%	0%	0%	0%
Undifferentiated						
Bronchioalveolar	13.3%	0%	0%	0%	28.6%	14.3%
Total	32.7%	14.5%	10.9%	4.4%	3.8%	2.5%

best prognosis in our group was adenocarcinoma with an overall five-year survival rate of 17.2%. The group of 16 patients with bronchio-alveolar carcinoma was too small for a valid comparison. In Table IV the survival of patients with resected lesions has been listed according to cell type and the presence of lymph node involvement. In this instance, the more favorable prognosis associated with adenocarcinoma becomes even more striking with a 50% five-year survival. Also apparent in this data is the effect on survival of any lymph node metastasis. In most of these patients lymph node involvement was found during pathological examination of the resected specimen. Vincent and his co-workers<sup>5</sup> have found, as we have, a statistically significant difference ( $P < 0.05$ ) in survival be-

tween Stage I and Stages II and III but no significant difference in survival between Stages II and III. The survival curves and overall survival rates confirm those reported in other large series.<sup>3-6,9,11</sup>

### SUMMARY

Our results, as many other studies, again call attention to the following points:

a) Surgery is still the most effective treatment for lung cancer but by and large provides long-term satisfactory results only for a limited number of patients. These results could be improved by earlier detection.

b) Postoperative survival can be extended by more careful selection for surgery using mediastinal lymph node biopsies more often rather

than by the application of more radical methods in the surgical technique itself.

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THAT THE MANIFOLDE ABUSES OF THIS VILE custome of Tobacco taking, may the better be espied, it is fit, that first you enter into consideration both of the first originall thereof, and likewise of the reasons of the first entry thereof into this Countrey. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Dean's Page

## THE WATER GETS HOTTER

*If you drop a frog in boiling water, he will jump right out.  
If you put him in tepid water and warm it gradually,  
that stupid frog will stay put until he boils to death.  
That's when you eat him."*

**Southern Wisdom**  
**Author unknown**

A new health manpower training bill will be considered in the next Congress. The bill needs attention from both the academic and practicing communities before it has a chance to become law. Why should private practitioners concern themselves with manpower training laws? It is certainly not unreasonable to assume that "The Health Professions Educational Assistance Act" has nothing to do with the private practice of medicine. Unfortunately, the assumption is incorrect. The government recognized long ago that one of Archimedes' principles works both ways: shifting the weight on a lever causes the lever to move in the desired direction.

We need to act in a way which recognizes that academic freedom (the short arm of the lever) and practice freedom are as closely related as siblings. The recent formation of a Section on Medical Schools by the American Medical Association is salutary recognition of our interdependence. This common front must be strengthened rapidly so that we can exert the pressure necessary to influence the thrust and content of new health manpower legislation.

Review of a draft of the latest administration proposal on "health professions educational assistance" leads to the conclusion that medical education and private practice will be squeezed by elements in this bill which could result eventually in federal control of health. Because this proposal has been developed by the Health Resources Administration (HRA), an agency which reflects the posture of the Executive Branch, even a "floater" such as this draft deserves careful scrutiny.

Four proposals deserve attention because they include programs to:

- a. Stabilize the output of training programs.
  - b. Improve the use of health personnel to enhance productivity in primary care practice.
  - c. Assure professional competency.
  - d. Strengthen health manpower planning.
- At first glance none of these programs would seem to have ominous overtones, nor would they appear inter-related. Analysis indicates otherwise.

## ENROLLMENT STABILIZATION

Many of us have been saying that the nation will have a surplus of physicians within a decade. Stabilization of enrollment or even a reduction in the number of medical students is probably a good idea. However, the proposed mechanism to stabilize enrollment, a three-year phase-out of the federal capitation support, the *quid pro quo* for enrollment increase in the first place, gives us insight relating to governmental motivation.

Although their flexibility will be sharply limited by the loss of capitation, it will not destroy most schools. Capitation phase-out, however, has been coupled with a conscious decision to force some schools to close because of financial distress. Some of the funds formerly used for capitation would be used to alleviate financial distress at "selected" schools. In the opinion of HRA, however, "it is not expected that the . . . grant authority would take care of the needs of all such (financially distressed) schools."

Perhaps some schools should close. If some schools are forced to close, however, the decision should be based on educational inadequacy rather than on financial instability or political utility. Federalization of the decision as to "who shall teach" (a fundamental tenet of academic freedom) is a near-certain outcome of the "selection" process. We should not be complacent just because none of the medical schools in North Carolina is on the brink of financial disaster.

## ENHANCE PRODUCTIVITY IN PRIMARY CARE

While we may be relieved that the administration recognizes we may be facing a future surplus of physicians, worry and confusion are caused by the proposal to improve the use of health professions personnel (a bureaucratic euphemism for non-physicians) to enhance productivity in primary care practice. The Department of Health, Education and Welfare (HEW) would be authorized to make grants to train additional nurse practitioners and physician assistants, and to create new roles and expanded functions for personnel other than physicians.

We support the concept that properly supervised personnel enhance the productivity of physicians. It seems counterproductive, however, to "expand roles" (the euphemism for preparation for independent practice) and to train additional personnel if we are producing a surplus of physicians.

If one looks for an economic and strategic motivation, the proposal becomes less confusing and more worrisome. Rather than following the sensible

resection. Mediastinoscopy should be performed in all patients presumed to have operable carcinoma of the lung.

**GORDON F. MURRAY, M.D.**  
Associate Professor of Surgery  
Division of Cardiothoracic Surgery  
University of North Carolina  
School of Medicine  
Chapel Hill, N.C. 27514

#### References

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7. Kirsh MM, Kahn DR, Gago O, et al.: Treatment of bronchogenic carcinoma with mediastinal metastases. *Ann Thorac Surg* 12:11-21, 1971.

## Bulletin Board

### NEW MEMBERS of the State Society

Ashburn, Philip Eugene, MD, (IM) 119 N. Boylan Ave., Raleigh 27603  
Baker, Vicki Vaughan (STUDENT) Apt. 10-E Sharon Heights, Chapel Hill 27514  
Boone, Stephen Christopher, MD, (NS) UNC Clinical Sciences Bldg., #148, Chapel Hill 27514  
Brandt-Sasin, Ilona, MD, (GP) 4870 Thales Rd., Apt. K, Winston-Salem 27104  
Czerwinski, Roman, MD, (INTERN-RESIDENT) 1505 Duke Univ. Road, Apt. 7E, Durham 27701  
Dasheiff, Richard Mitchell, MD, (INTERN-RESIDENT) 4105 New Bern Place, Durham 27707  
Davidson, Charles Stephen, MD, (FP) % Outer Banks Health Center, Nags Head 27959  
Garrison, Michael Stephen (STUDENT) 614-B Hibbard Dr., Chapel Hill 27514  
Harris, Donald Philip, MD, (IM) 208 Foust St., Asheboro 27203  
Hollerman, Jeremy Jacob, MD, (INTERN-RESIDENT) 413 Lawndale Dr., Winston-Salem 27104  
Karam, Michael Qustandi, MD, (IM) 3801 Computer Dr., Ste. 212, Raleigh 27609  
Lambert, James Royall, MD, (INTERN-RESIDENT) 1000 W. End Blvd., Winston-Salem 27101  
Lavender, Dick Redmond, MD, (ORS) 200 E. Northwood St., Greensboro 27401  
Lee, Il Sung, MD, (IM) P.O. Box 370, Enka 28728  
Lesesne, Carroll Boutell (STUDENT) Box 2812, Duke Med. Ctr., Durham 27710  
Mahafee, W. Collins, MD, (FP) 2601-F Oakcrest Ave., Greensboro 27408  
Markello, James Ross, MD, (PD) 413 Longmeadow Rd., Greenville 27834  
Minard, Raymond Bruce, (STUDENT) 215-G Stancill Dr., Greenville 27834  
Newton, John Thomas (STUDENT) 49 Fidelity Court Apts., Carrboro 27510  
Niazi-Sasin, Abdolkakim, MD, (IM) 300 N. Washington St., Wadesboro 28170  
Nieland, Robert Bruce, MD, (FP) 24 Second Ave., NE, Hickory 28601  
Novitsky, Mark A., (STUDENT) 1914 Beach St., Winston-Salem 27103  
Patel, Suresh Ambalal, MD, (P) 501 Billingsley Road, Charlotte 28211  
Strout, John Joseph, MD, (INTERN-RESIDENT) 1012 W. End Blvd., Winston-Salem 27103  
Verma, Harish Chander, MD, (P) 201 Whittington Circle, Greenville 27834

Whiteside, Donald Campbell (STUDENT) 628-C Fidelity St. Carrboro 27510

### WHAT? WHEN? WHERE? In Continuing Education

Please note: 1. The Continuing Medical Education Programs at Bowman Gray, Duke, East Carolina and UNC Schools of Medicine, Dorothea Dix, Wayne County Hospital and Burroughs Wellcome Company are accredited by the American Medical Association. Therefore CME programs sponsored or co-sponsored by these schools automatically qualify for AMA Category I credit toward the AMA's Physician Recognition Award, and for North Carolina Medical Society Category A credit. Where AAFP credit has been requested or obtained, this also is indicated.

2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information".

#### PROGRAMS IN NORTH CAROLINA

##### November 2-4

Ambulatory Pediatric Society Meeting  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

##### November 8

"Practical Pediatrics"

Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15

Credit: 3 hours, AMA Category I

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville, N.C. 27834

##### November 10

Seminar on Aging

Fee: \$35

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

##### November 10

9th Annual Duke Symposium on Orofacial Anomalies

Place: Duke University Medical Center

For Information: Galen Quinn, D.D.S., P.O. Box 3806, Duke University Medical Center, Durham 27710



# COMPATIBILITY



## Does it influence your choice of a peripheral/cerebral vasodilator\*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
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**\*Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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bronchodilator therapy
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**Indications:** For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

**Warnings:** Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

**Precautions:** Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Merabollines of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitroazanaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

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#### November 16-18

11th Annual Scientific Assembly of the North Carolina Academy of Family Physicians  
Place: Sheraton Inn, Charlotte  
Fee: \$30  
For Information: Mr. Edwin Davis, Executive Director, North Carolina Academy of Family Physicians, P.O. Drawer 11268, Raleigh 27604

#### November 29

Nutrition in Medical Care 1978  
Place: Lee County Hospital, Sanford  
Sponsors: Lee County Medical Society and Eaton Laboratory  
Fee: \$6 for non-M.D.'s  
Credit: 3.5 hours  
For Information: R. S. Cline, M.D., Director of Continuing Medical Education, Lee County Hospital, Sanford 27330

#### December 1-2

American College of Physicians — North Carolina Society of Internal Medicine Annual Meeting  
Place: Sheraton Inn, Charlotte  
For Information: Norman H. Garrett, M.D., 1038 Professional Village, Greensboro 27401

#### December 2

Pregnancy, Birth, and Infancy: Origins of Attachment  
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### December 11-15

Industrial Toxicology  
For Information: Mario Battigelli, M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

#### December 13

Office Gynecology  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category 1  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January-February

District Medical Society Postgraduate Course  
Place: Edenton, Ahoskie  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### January 10

Immunological Aspects of Malignancy  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category 1  
For Information: F. M. Simmons Patterson, Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January 26-27

Clinical Urology  
Place: Babcock Auditorium  
Sponsors: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### February 1-3

Wack Surgical Society Meeting  
Place: Berryhill Hall  
For Information: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill 27514

#### February 2-3

North Carolina Conference for Medical Leadership  
Place: Sheraton Crabtree Motor Inn, Raleigh  
Sponsors: North Carolina Medical Society  
For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

#### February 14

Psychopharmacology Update  
Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours; AMA Category 1

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### February 16-20

Basic Electroencephalography  
Credit: 30 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### February 19-23

Microvascular Surgery Workshop  
Credit: 40 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### March 3-4

Anesthesiology  
For Information: David Brown, M.D., Department of Anesthesiology, UNC School of Medicine, Chapel Hill 27514

#### March 7-10

Internal Medicine 1979  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 9-10

Frank R. Lock Symposium in Obstetrics and Gynecology  
Place: Bowman Gray School of Medicine  
For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### March 9-10

2nd Outcome Workshop  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 14

Recent Advances in Surgical Care  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category 1  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### March 29-30

Annual Cancer Research Symposium  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 2-6

Chest Radiology  
Place: Ramada Inn, Durham  
Fee: \$300  
Credit: 30 hours  
For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

#### April 11

Current Clinical Problems in Family Practice  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### April 12

Greensboro Academy of Medicine Annual Medical Symposium — Rheumatic Diseases  
Place: Jefferson-Standard Club, Greensboro  
Credit: 6 hours  
For Information: William Harrison Turner, M.D., 1030 Professional Village, Greensboro 27401



#### April 18-20

Rainey Orthopedic Lectures

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 20-22

Spring Radiology Seminar

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building, 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 27-28

12th Malignant Disease Symposium

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

### ITEMS OF SPECIAL INTEREST

#### December 7-10

Thirty-Second American Medical Association Winter Scientific Meeting

Place: Las Vegas

For Information: Department of Meeting Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

#### February 12-16

Current Concepts in Diagnostic Radiology

Place: Acapulco Princess Hotel, Mexico

Sponsor: Department of Radiology, Duke University Medical Center

Fee: \$250

For Information: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham 27710

Abdominal Real Time Sonography Courses

A series of six week-long courses on the use of Real Time Ultrasound in abdominal studies will be offered at Bowman Gray School of Medicine on the following dates: December 4-8, 1978; March 12-16, June 11-15, July 16-20 and December 9-13, 1979. Participants will receive 30 hours of Category I credit per week.

For further information, please contact, James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem 27103

### PROGRAMS IN NEARBY STATES

#### November 2-3

Clinical Evaluation and Management of Chronic Pain

Place: University of Tennessee Center for the Health Sciences, Memphis

Credit: 10 hours; Category 1

For Information: Mrs. Grace Wagner, Conference Coordinator, University of Tennessee Center for the Health Sciences, 800 Madison Avenue, Memphis, Tennessee 38163

#### November 5-8

Second Annual Symposium on Computer Applications in Medical Care

Place: Washington, D.C.

Sponsors: Medical College of Virginia Department of Continuing Medical Education, George Washington University Medical Center, Georgetown University Medical School, IEEE Computer Society

For Information: Department of Continuing Medical Education, Medical College of Virginia, MCV Station, Richmond, Virginia 23298

#### November 18

Third Annual Critical Care Conference — The Management of Serious Infections

Place: George Mason University, Fairfax, Virginia

Fee: \$50

Credit: 8 hours

Sponsor: The Fairfax Hospital

For Information: J. Barry Newman, Coordinator, Continuing

Medical Education, The Fairfax Hospital, 3300 Gallows Road, Falls Church, Virginia 22046

#### January 22-26

Sixth Annual Meeting of the Southern Clinical Neurological Society, Pier 66 Hotel, Fort Lauderdale, Florida

For Information: B. J. Wilder, M.D., Secretary, University of Florida Hospital, Gainesville, Florida

The items listed in the above column are for the six months immediately following the month of publication. Requests for list should be received by "WHAT? WHEN? WHERE?", P.O. Box 27167, Raleigh 27611, by the 10th of the month prior to the month which they are to appear. A "Request for Listing" form is available on request.

## AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

We are happy to report that H.B. 540 was ratified the last day of the 1978 session of the General Assembly, which appropriated \$210,000 to begin comprehensive health education programs in one unit each of the eight education regions, to continue the position of state consultant, and, to a limited extent, support curriculum development and a 17-member advisory committee.

We are grateful for the groups and individuals who supported this legislation, particularly Rep. Cly Auman and Sen. Lawrence Davis, and for the support of newspapers and television stations, especially WUNC, WRAL and WXII. With this beginning, we must continue to look toward the 10-year goal. Although eight school units will have health coordinators through this legislation and six others are locally funded, there are still 131 school units in North Carolina with limited and fragmented health education programs.

MARTHA MARTINAT  
Past President

### News Notes from the

## UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

A researcher in the School of Medicine has received a \$170,157 grant from the National Cancer Institute to study how chemical compounds found in a variety of common products can change in the body to cause cancer or damage cells in other ways.

Dr. Curtis Harper, associate professor of pharmacology, is examining the threat of organohalogen compounds used as tranquilizers, pesticides, anesthetics, degreasers and many other agents. He will study ways that organohalogens may damage



stroy liver and lung cells and how certain enzymes  
vern this destructive process.

\* \* \*

A pediatric neuropharmacology clinic has been es-  
lished at UNC to study children who take  
ychoactive drugs.

Funding by the National Institute of Child Health  
d Human Development is expected to total \$500,000  
ring a four-year period.

Heading the overall research program is Dr. George  
eese, professor of psychiatry and pharmacology.  
Tom Gualtieri, assistant professor of psychiatry,  
ll direct the clinical evaluations.

The research project is the first of its kind in the  
untry developed specifically for children with de-  
velopmental disabilities who need to be on drugs.  
formation gathered in the study should help physi-  
ans decide not only whether a child needs  
ychoactive drugs, but which drug, in what dosage,  
d when and for how long the drug should be ad-  
nistered.

Gualtieri will assess children taking Ritalin  
(methylphenidate) and Mellaril (thioridazine), two of  
e psychoactive drugs most commonly prescribed for  
ildren.

Research on clotting and bleeding disorders will be  
the focus of a new Center for Hemostasis and Throm-  
bosis at UNC. Dr. Harold Roberts, professor of medi-  
cine and pathology, has been named director.


For more than 30 years, the UNC medical school  
has been recognized as a world leader in research  
related to coagulation disorders. Currently, studies in  
this field involve more than 30 fulltime investigators in  
seven medical school departments, the School of  
Dentistry and the Department of Chemistry.

Roberts said the new center will coordinate this  
research so that findings can be applied to the treat-  
ment of patients as quickly as possible.

\* \* \*

Dr. John T. Gwynne, assistant professor, has re-  
ceived a \$19,000 March of Dimes grant to study how  
cholesterol is stored, carried and absorbed in the  
body. His research may help physicians understand  
how cholesterol builds up in the walls of arteries and  
how this process, atherosclerosis, can be prevented or  
reversed. Gwynne will study how lipoproteins absorb  
and carry cholesterol. Because arterial walls are dif-  
ficult to examine, he will focus on the adrenal glands,  
which absorb cholesterol to form steroid hormones.

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Dr. Christopher C. Fordham III, dean, began in August a six-month leave of absence during which he will study various aspects of public planning and financing for health care. He expects to spend considerable time studying systems in the United Kingdom and Canada, as well as practices in the United States. The study is partially supported by a grant from the Josiah Macy Jr. Foundation. Fordham has announced his intention to relinquish the deanship next June 30.

\* \* \*

Faculty promotions to associate professor in the School of Medicine: Dr. Nortin M. Hadler, medicine and bacteriology and immunology; Dr. John C. Hisley, obstetrics and gynecology; Drs. Eng-Shang Huang and Henry R. Lesesne, medicine; Dr. J. David Leander, pharmacology; Drs. William J. Arendshorst and Paul B. Farel, physiology; Drs. Priscilla D. Boekelheide and Kenneth C. Mills, psychiatry; Dr. Robert E. Cross, pathology and medicine, and Dr. Gail T. Wertz, bacteriology and immunology. Dr. Bozman R. Reeves Jr. has been promoted to assistant professor of medicine.

\* \* \*

Dr. William B. Wood, associate professor of medicine, has been appointed director of the office of continuing education and alumni affairs at the School of Medicine.

Wood, who earned both his B.S. and M.D. degrees at UNC-CH, succeeds the late Dr. Oscar L. Sapp III.

A member of the faculty for 15 years, Wood has a special interest in pulmonary diseases and directs the adult allergy clinic at North Carolina Memorial Hospital.

He will continue his teaching and clinical work in addition to his new duties.

\* \* \*

Sandra K. Evans has been named vice chairman of the Department of Nursing at North Carolina Memorial Hospital. A registered nurse, she has served as clinical nurse coordinator for the adult intensive care units at the hospital for the past five years. Since March of this year, she has also been the nursing department's representative on the emergency room management committee, a responsibility she will retain in her new position.

\* \* \*

Dr. Mary Ellen Jones has been appointed professor and chairman of the Department of Biochemistry and Nutrition, succeeding Dr. J. Logan Irvin, who relinquished the post after more than 20 years.

Jones comes to Chapel Hill from the University of Southern California Medical School where she has been a professor of biochemistry since 1971.

She earned her B.S. degree from the University of Chicago and her Ph.D. degree from Yale and taught in

## BRIEF SUMMARY OF PRESCRIBING INFORMATION

### ANTIMINTH® (pyrantel pamoate) ORAL SUSPENSION

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

**Precautions:** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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he graduate Department of Biochemistry at Brandeis University, where she was a Scholar of the American Cancer Society. She served as an associate professor, then as professor in the UNC-CH Departments of Biochemistry and Zoology from 1966 through 1971.

Jones is the author of more than 50 research papers and is a member of the editorial board of the Journal of Biological Chemistry.

\* \* \*

Drs. Mahesh Varia and Mark Kirsch, assistant professors of radiology, have received a \$1,870 Medical Faculty Grant from the N.C. United Community Service to continue their research in hyperthermia and radiation therapy.

\* \* \*

Dr. Joseph S. Pagano, professor of medicine and bacteriology and immunology and director of the Cancer Research Center, presented "Molecular Pathogenesis of Burkitt's Lymphoma, Nasopharyngeal Carcinoma and Infectious Mononucleosis" at the National Cancer Institute in Bethesda, Maryland.

\* \* \*

Deborah Glosson, staff occupational therapist in psychiatry, was appointed N.C. chairperson of the Special Interest Group in Sensory Integration and will serve as liaison to the American O. T. Association Special Interest Group in Sensory Integration.

\* \* \*

Dr. James N. Hayward, chairman and professor of neurology, was an external consultant reviewing the Department of Neurology for the University of Kentucky College of Medicine.

\* \* \*

Dr. H. Robert Brashear, professor of orthopaedic surgery, was presented the Teacher's Cup for the Musculoskeletal Course by second year students. The award is given to the faculty member contributing most to the students' education during the Musculoskeletal Course. The students presented the Resident Award for the same course to Dr. John P. Spencer, chief resident of orthopaedic surgery.

\* \* \*

Dr. Paul A. Obrist, professor of psychiatry, has been elected a fellow of the American Psychological Association and of the American Association for the Advancement of Science. Obrist was a lecturer at the annual meeting of the Society for Psychosomatic Research in London in November, 1977, and in the "Clinical Advances in Bio-behavioral Sciences" series organized by the Center for Bio-organic Studies, University of New Orleans. He spoke at the international conference on the "Orienting Reflex in Humans" in the Netherlands in June.

Dr. Kenneth Sugioka, professor and chairman of anesthesiology, presented "The Effects of Hypocarbemia on Organ Systems" at the 1978 Annual Anesthesiology Review Course for Society of Air Force Anesthesiologists in San Antonio.

\* \* \*

R. Bruce Steinbach, director of respiratory therapy at N.C. Memorial Hospital, presented "Respiratory Care of the Neonate" at the Region V Respiratory Therapy meeting in Arlington, Va. He was also an oral examiner for the National Board for Respiratory Therapists examination in Atlanta.

\* \* \*

Faculty members who participated in the Public Health Nutrition Update short course program include: Dr. Roy V. Talmage, professor of surgery and Dr. T. Kenney Gray, associate professor of medicine, who participated on a reaction panel, and Dr. William Herbert, assistant professor of ob-gyn, who presented "Vitamin and Mineral Supplements for the Pregnant Woman."

\* \* \*

Dr. Richard L. Clark, associate professor of radiology and director of diagnostic radiologic research, presented "Radiological Evaluation of a New Experimental Model of Erosive Synovitis in Rats" and Dr. John T. Cuttino Jr., assistant professor of radiology, presented "The Urothelial Microvascular Re-

---

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sponse to Chronic Renal Inflammatory Disease" at the 26th annual meeting of the Association of University Radiologists in San Antonio. Dr. W. Deanes Bidgood Jr., first-year resident in radiology, presented "Pyelovenous Backflow During Retrograde Pyelography in Renal Vein Thrombosis" and Dr. James H. Scatliff, professor and chairman of radiology, presented "Quantitative Accuracy of CT Evaluation of Spinal Stenosis."

\* \* \*

Drs. Clayton E. Wheeler Jr., Robert A. Briggaman and W. Mitchell Sams Jr., professors of dermatology, attended the annual meeting of the Society for Investigative Dermatology in San Francisco. Sams is secretary-treasurer of the society and, along with Briggaman, is a member of the board of directors.

\* \* \*

Dr. William A. Richey, chief resident of the department of radiology, was elected chairman of the American Association of Academic Chief Residents in Radiology. The organization represents chief radiology residents across the country, especially through the American College of Radiologists. Richey is a graduate of the UNC-CH School of Medicine.

\* \* \*

Dr. C. Leon Partain, research associate in radiol-

ogy, has received a \$28,000 grant from the National Institute of Neurological and Communicative Disorders and Stroke, National Institutes of Health, to study cerebrospinal fluid kinetics using contrast enhanced serial computed tomography. The project involves cooperative efforts among physicians in radiology, neurosurgery and neurology.

\* \* \*

Dr. G. Yancey Gillespie, research assistant professor of pathology, Cancer Research Center, presented "Resurgence of Killing *in vitro* by Noncytolytic Tumor-Draining Lymph Node Cells" at the 62nd annual meeting of the Tumor Immunology Section of the American Association of Immunologists in Atlanta.

\* \* \*

Dennis R. Barry, general director of North Carolina Memorial Hospital, was named chairman of the board of trustees of the North Carolina Hospital Association. NCHA is a volunteer, non-profit organization which promotes the development, improvement and perpetuation of hospitals and related health services for the people of North Carolina. About 95% of the state's hospitals belong to the association.

\* \* \*

Dr. Eng-Shang Huang, assistant professor of medicine, presented "Identification of Human Cyto-

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negaloviruses: New Approaches" at The Wistar Institute and Children's Hospital of the Philadelphia Virology Division.

\* \* \*

Dennis R. Barry, general director of North Carolina Memorial Hospital, Dr. William E. Easterling, chief of staff, Dr. Gary Berger, assistant professor of ob-gyn, Dr. Carol Mittlestaedt, assistant professor of radiology, and Dr. Roger Salisbury, associate professor of surgery, made a presentation about the N.C. Memorial Hospital to the Sir Walter Cabinet in Raleigh. The cabinet is comprised of spouses of members of the General Assembly.

\* \* \*

The Eleanor Clarke Slagle Lectureship Award of the American Occupational Therapy Association has been awarded to L. Irene Hollis, director of occupational therapy and the hand rehabilitation center at UNC.

The award was established in 1953 to honor the founder of the first formal school for professional training of occupational therapists, and to recognize merit and achievement in the field of occupational therapy.

For more than 10 years, Hollis has pioneered in the development of the function of occupational therapists in hand rehabilitation.

\* \* \*

The most up-to-date review of current knowledge, research and clinical practice in the area of autism is presented in a new book co-edited by Eric Schopler, M.D., UNC-CH professor of psychiatry and psychology.

*Autism: A Reappraisal of Concept and Treatment* is a collection of 34 chapters, many of which are based on papers presented at the International Symposium on Autism held in St. Gallen, Switzerland. Michael Rutter from the University of London is co-editor. Eric Schopler, an authority on autism, is director of EACCH (Treatment and Education of Autistic and Related Communications handicapped Children). It is the nation's only statewide autism program which pioneered an integrated research and treatment approach for these children and their parents.

#### News Notes from the—

#### DUKE UNIVERSITY MEDICAL CENTER

Tobacco, cotton and grains will come under close scrutiny here over the next few years as scientists attempt to pin down the causes of certain lung diseases.

Supported by two grants totaling \$873,114 from the National Institute of Environmental Health Sciences (NIEHS), the Duke researchers are beginning a major

study of naturally occurring minerals that stick to crops in the field and later may lead to lung disease when inhaled in dust or smoke.

"Our concern is lessening the danger of exposure to things that we expect people will be exposed to for some time," said Dr. William Gutknecht, assistant professor of chemistry and co-director of the project. "The goal is not to put down these products or the industries they support, but rather to make them safer if possible."

The study is a multidisciplinary effort involving pulmonary physicians, physiologists, analytic and organic chemists, pathologists, biochemists and pediatricians, Gutknecht said.

Eleven Duke scientists will be involved directly in the research, while others from Duke, NIEHS and the Research Triangle Institute will serve as consultants.

Dr. William S. Lynn Jr., professor of medicine and associate professor of biochemistry, is project director and principle investigator. Dr. Johannes A. Kylstra, professor of medicine and associate professor of physiology, is serving with Gutknecht as co-director.

Other Duke scientists involved are Dr. S. N. Bhattacharyya, Mary C. Rose and Saura Sahu, research associates in biochemistry and medicine, Hal K. Hawkins and Phillip C. Pratt, assistant professor and professor of pathology, respectively; John Shelburne, director of the V.A. Hospital's electron microscopy laboratory and assistant professor of pathology; Hernan Giraldo, research associate in medicine; and Dr. Alexander Spock, professor of pediatrics.

Gutknecht said the North Carolina Lung Association



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tion is also supporting the research with a grant of \$2,500.

\* \* \*

The Alexander von Humboldt Foundation in Bonn, West Germany, has selected a Duke physician to receive one of its annual awards for senior United States scientists.

The award will enable Dr. Michael K. Reedy, associate professor of anatomy, to spend a year in Heidelberg conducting research at the Max Planck Institute for Medical Research and the European Molecular Biology Laboratory.

Reedy, whose scientific work is aimed at explaining how muscles contract, will be studying the arrangement and behavior of certain tiny muscle structures known as myosin crossbridges.

\* \* \*

A Duke faculty member has been named president-elect of the Society of Teachers of Family Medicine (STFM).

Dr. William J. (Terry) Kane, associate professor of community and family medicine and director of the Duke-Watts Family Medicine Program, was elected to the post during the organization's 11th annual conference in San Diego.

As president-elect of the STFM, Kane will serve as liaison to the American Academy of Family Physicians' Committee on Legislation and Governmental Affairs and to the new academic section of the College of Family Physicians of Canada.

\* \* \*

Dr. James B. Wyngaarden, chairman of the Department of Medicine, has been installed as president of the Association of American Physicians, the nation's oldest and most exclusive society of physicians in academic medicine.

Wyngaarden, who is Frederic M. Hanes Professor of Medicine, assumed the post at the group's annual meeting in San Francisco.

Earlier this year, the Southern Society for Clinical Investigation honored him with its annual Founder's Medal, calling the physician "a leader in the advancement of medical research, teaching and academic principles."

\* \* \*

Three residents in family medicine have received national awards.

Drs. Kathy Andolsek and John Hartman, second-year residents in the Duke-Watts Family Medicine Program, are winners for 1978 Mead Johnson Awards for Graduate Training in Family Practice. Third-year resident Dr. Albert A. Meyer is a recipient of a Warner/Chilcott Teacher Development Award.

Andolsek is from Bethesda, Md. She earned her baccalaureate degree from Northwestern University and received her M.D. degree there in 1976.

Hartman, a native of Florida, is a 1970 graduate of

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**Indications:** Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

**Important Note:** When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

**Precautions:** The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

**Adverse Reactions:** Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

**Usual Dosage:** Adults: 250 mg. q. 6h.  
Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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10 times more active against strep than staph.

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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



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Virginia Polytechnic Institute and received his M.D. from the University of Miami in 1976.

Meyer is a 1970 graduate of Manhattan College and earned his M.D. degree from Downstate Medical Center in New York in 1975.

\* \* \*

The American Society for Pharmacology and Experimental Therapeutics has awarded its John J. Abel Award in Pharmacology to Dr. Robert J. Lefkowitz, professor of medicine.

Lefkowitz received the award, which consists of a bronze medal and \$2,000 donated by the Eli Lilly drug company of Indianapolis at the society's annual meeting in Atlantic City.

The award is presented annually to stimulate fundamental research in pharmacology and experimental therapeutics by young investigators.

Lefkowitz, 35, was selected for his contributions to the field of hormone and drug receptor research.

\* \* \*

Dr. Daniel B. Menzel of the Department of Pharmacology and Dr. David S. Werman of the Department of Psychiatry have been promoted to full professor.

Nine new faculty members include Dr. Jonathan R. T. Davidson, associate professor of psychiatry, and eight assistant professors in the departments indicated:

Drs. Rosalind Coleman, pediatrics; Philip J. Dubois, radiology; Arnold S. Grandis, obstetrics and gynecology; Linda K. Magness, radiology; David S. Pisetsky, medicine; Charles K. Prokop, medical psychology; J. Connell Shearin Jr., plastic and maxillofacial surgery; and Ronald J. Taska, psychiatry.

#### News Notes from the—

### EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

Dr. Carl Robert Morgan, formerly professor of anatomy at Indiana University, has been named chairman of the Department of Anatomy at the School of Medicine.

Morgan's major research interest is experimental diabetes. He is best known for developing a method of radioimmunoassay for insulin.

He received his undergraduate degree from Wartburg College, Waverly, Iowa, and his master's degree from the University of Nebraska. He completed his Ph.D. at the University of Minnesota and did postdoctoral training there under Dr. Arnold Lazarow.

\* \* \*

Dr. Thomas F. O'Brien has been appointed professor of medicine and will be responsible for developing

the medical school's gastroenterology section. Previously, O'Brien was professor of medicine and chief of gastroenterology at the Bowman Gray School of Medicine.

The author of numerous publications on digestive diseases, O'Brien has done considerable work on disease-caused malnutrition and diet therapy for gastrointestinal disorders.

He received his undergraduate degree from Princeton University and his M.D. from Yale University. He completed residency training in gastroenterology at Cornell Medical Center.

\* \* \*

Dr. Loretta Kopelman has joined the School of Medicine as associate professor of pediatrics. She is the author of numerous articles on ethical and legal problems involving newborns, children, retarded persons and medical research, and she will teach the philosophy of medicine and medical ethics to medical students and residents.

Prior to joining ECU, Kopelman was assistant professor at the University of Rochester. She received her undergraduate and master's degrees from Syracuse University and completed her Ph.D. at the University of Rochester.

\* \* \*

Dr. S. Gregory Iams, assistant professor of physiology, has received a \$5,000 grant from the N.C. Heart Association to study the role of the thyroid gland in the development of hypertension. The project is designed to determine if depressing the action of the thyroid gland will depress or inhibit high blood pressure.

Iams is studying the disease in the spontaneously hypersensitive rat to see if hormones secreted by the thyroid gland act in conjunction with the nervous system to cause high blood pressure in the animals.

Iams has conducted previous research on the role of the endocrine system in hypertension.

\* \* \*

The Weyerhaeuser Company has given a grant of \$110,000 to the ECU Medical Foundation. The fund will assist the medical school in recruiting new faculty and extending its clinical faculty's expertise to the eastern region.

\* \* \*

Dr. A. H. Woodworth, a Greenville family physician, has been named director of the Eastern Carolina Family Practice Center, the primary care facility operated by the School of Medicine.

Woodworth received his undergraduate degree from Hiram College, Ohio, and his M.D. from Albar Medical College. He did postgraduate training at the Cleveland Clinic.

He came to Greenville in 1971 as a physician with the ECU Student Health Service and a year later established a group practice in family medicine.

Site work is nearly complete on the 40 acres of land that by summer of 1981 will be the permanent home of the School of Medicine. The tract is located adjacent to Pitt County Memorial Hospital.

Dr. Dean Hayek, assistant dean, says construction has already begun on the Animal Research Building and the utility plant. Occupancy for these facilities is scheduled for the fall of 1979.

Blueprints of the 441,000 square foot, 9-story Medical Science Building have been circulating through the departments as chairmen meet with Hayek to discuss office and lab space.

Construction is scheduled to begin in January or February, 1979.

#### News Notes from the—

### **BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY**

Dr. John H. Felts, professor of medicine, has been named associate dean of Bowman Gray, with responsibilities for the student admissions program.

Felts, a nephrologist, succeeds Dr. B. Lionel Truscott, who headed the admissions program since 1973. Truscott recently resigned as associate dean to return to fulltime service with the Veterans Administration. Felts, who joined the Bowman Gray faculty in 1955, is editor of the NORTH CAROLINA MEDICAL JOURNAL, a position he has held for the past four years.

He and his staff in the admissions office will begin immediately receiving and processing applications for admissions in Bowman Gray's 1979 entering class. Bowman Gray received 4,722 applications for the 108 places in the 1978 entering class.

Felts will continue to have some teaching and patient care responsibilities, particularly as they relate to kidney disease.

He is a graduate of Wofford College and holds the M.D. degree from the Medical University of South Carolina. He took postdoctoral training at the Walter Reed Army Hospital and North Carolina Baptist Hospital.

\* \* \*

Dr. B. Moseley Waite, professor of microbiology at the Bowman Gray School of Medicine, has been named chairman of the school's Department of Biochemistry.

Waite, who is internationally known for his work on cell membranes, succeeds Dr. Cornelius F. Strittmatter, the Odus M. Mull professor of biochemistry, who was chairman of the department for the past 17 years. He asked to be relieved of his administrative duties in order to return to fulltime teaching and research.

Waite was recommended by a search committee, which was appointed last year.

He will head a research-intensive department in which nine faculty members are conducting projects on a broad spectrum of subjects relating to body chemistry. The work, supported by 26 active grants, is interrelated with research conducted by several other departments, including the Specialized Center of Research (SCOR) in Atherosclerosis, the Cancer Research Center, and the Departments of Microbiology and Immunology, Medicine, Physiology and Pharmacology, and Obstetrics and Gynecology.

There are 10 graduate students enrolled in the department's programs leading to the M.S. and Ph.D. degrees in biochemistry. Two postdoctoral trainees also are studying in the department.

Waite, who joined the Bowman Gray faculty in 1967, is a graduate of Rollins College and holds the Ph.D. degree from Duke University, where he studied three years as a postdoctoral fellow of the U.S. Public Health Service and the American Cancer Society. He also completed two years of research at the University of Utrecht and studied as an advanced postdoctoral fellow of the American Heart Association.

\* \* \*

The Bowman Gray School of Medicine has joined the North Carolina Heart Association in a major program involving the prevention, detection and treatment of stroke.

The heart association has received a three-year, \$1,463,000 grant from the National Institute of

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Neurological and Communicative Disorders and Stroke to develop the program.

The Research Triangle Institute and the University of North Carolina School of Public Health (departments of epidemiology and health education) also are involved in the program.

Dr. James F. Toole, professor and chairman of Bowman Gray's Department of Neurology, is the program's principal investigator. Dr. Lawrence C. McHenry Jr., professor of neurology, is the principal co-investigator.

The program involves a 15-county region in southeastern North Carolina. Using existing community resources as well as developing new resources, the program will aid in the creation of stroke teams. The teams will consist of health professionals in hospitals and out in the communities.

Bowman Gray will provide educational and medical support in the overall effort. Because of the existence of a federally funded stroke research center at Bowman Gray, it has the experience with the newer methods of diagnosing and treating stroke which can be disseminated through the new program's educational efforts.

\* \* \*

The Bowman Gray School of Medicine has been chosen to conduct the nation's first laboratory and

clinical evaluations of a new British-made machine for studying the veins and arteries.

The school was chosen because it is "a center for excellence in ultrasound," according to the machine's developer, Peter Fish, senior physicist at Kings College Hospital in London.

The new machine, called MAVIS (Mobile Artery and Vein Imaging System), is expected to be useful in uncovering problems in the blood vessels which might cause strokes and disease of the vascular system.

MAVIS uses ultrasound to provide an accurate measurement of blood flow and turbulence. MAVIS can probe blood vessels faster than existing ultrasound equipment and is sensitive enough to detect small buildups of plaque on vessel walls, according to Fish.

\* \* \*

Dr. C. Douglas Maynard, professor and chairman of Bowman Gray's Department of Radiology, has been installed as president of the Society of Nuclear Medicine.

He was installed at the society's annual meeting in Anaheim, Calif.

Maynard has been vice president of the society for the past year and has served as a member of the editorial board of the Journal of Nuclear Medicine.

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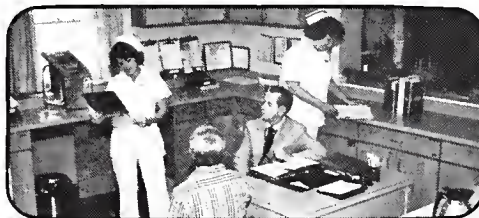


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He also has served as president of the Southeastern chapter of the Society of Nuclear Medicine.

\* \* \*

Dr. Thomas E. Clark, associate professor of sociology, has been elected a Fellow in the American Association of Marriage and Family Counselors.

\* \* \*

Dr. David J. Goode, associate professor of psychiatry, has been named chairman of the Research Development Committee and chairman of resident education at Broughton Hospital.

\* \* \*

Dr. Clara M. Heise, assistant professor of radiology, has been reelected secretary of the national Clinical Radioassay Society.

\* \* \*

Dr. J. M. McWhorter, assistant professor of neurosurgery, has been elected to the committee on Medical Aspects of Sports of the North Carolina Medical Society. He also was appointed chairman of the Scientific Program Committee for the 1979 Annual Sports Symposium.

\* \* \*

Dr. J. Maxwell Little, professor of pharmacology, and Dr. I. Meschan, professor of radiology, have been selected for inclusion in the 4th edition of *Who's Who in the World*. Little also has been selected for inclusion in the 40th edition of *Who's Who in America*.

\* \* \*

Dr. George Podgorny, clinical associate professor of surgery, received an Alumni Citation from Maryville College "in recognition of outstanding service to mankind through vocational achievement and personal dedication, and grateful acknowledgement of honor brought and service rendered to Maryville Col-

lege." He also has been reelected president of the American Board of Emergency Medicine.

\* \* \*

Dr. George D. Rovere, associate professor of orthopedic surgery, has been reappointed to the Committee on the Medical Aspects of Sports of the North Carolina Medical Society.

\* \* \*

Dr. Earl Schwartz, instructor in surgery, has been appointed chairman of the CPR subcommittee of the Forsyth Heart Association.

\* \* \*

Dr. Marvin B. Sussman, professor of sociology, has been appointed to a two-year term to the Child and Family Development Research Review Committee, Administration for Children, Youth and Families of H.E.W.

\* \* \*

Dr. Richard L. Witcofski, professor of radiology, has been reappointed chairman of the Audiovisual Subcommittee of the Society of Nuclear Medicine for 1978-79.

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#### MAC ROY GASQUE, M.D.

Dr. Mac Roy Gasque, vice president and director, health affairs, Olin Corporation, Stamford, Conn., and former plant medical director, Olin Corporation, Pisgah Forest, N.C., is the first recipient of the Outstanding Medical Alumnus Award of the University of Virginia School of Medicine. Dr. Gasque, presently residing at Fortune Cove, Brevard, N.C., graduated from the University of Virginia School of Medicine in 1944 and was formerly lecturer in industrial medicine at the Duke University Medical Center and the Bowman Gray School of Medicine of Wake Forest University.

# Month in Washington

Kennedy-Labor forces upstaged President Carter's release of national health insurance principles by denouncing them as "unacceptable overall" a day before they were to have been made public.

Senator Edward Kennedy (D-Mass.) and AFL-CIO President George Meany in a joint press conference a day before the scheduled release of the NHI principles charged Carter with "a failure of leadership" and of "misreading the mood of the people."

A day later President Carter called for a NHI plan that through a step-by-step process would ultimately lead to comprehensive health coverage for all. He directed Health, Education and Welfare Secretary Joseph A. Califano to develop a tentative plan as soon as possible which embodied ten White House derived NHI principles.

James H. Sammons, M.D., Executive Vice President of the American Medical Association, stated:

"The American Medical Association is pleased that the President appears to have recognized the many positive aspects and strengths of our health care system in the process of presenting his national health insurance principles. Many of the NHI principles announced by the President seem to be consistent in whole or in part with similar principles that have been endorsed by the American Medical Association. These include the need for comprehensive health care coverage, freedom of choice of physician, hospital, and health care delivery system, the provision of quality care, and the utilization of the private health insurance industry. The AMA has introduced legislation embodying these principles in the Congress since 1970."

Charging that the President's principles were "simply too little and too late" to form the basis of a program, the Kennedy-Meany faction stated that while it "hoped the current break with the President could be repaired — it would proceed on its own to develop a NHI program that will meet the urgent and basic needs of the people of America."

The President's NHI principles:

1.) The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.

2.) The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.

3.) The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals and health delivery systems.

4.) The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5.) The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.

6.) The plan will involve no additional federal spending until fiscal 1983, because of tight constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.

7.) The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.

8.) The plan should include a significant role for the private insurance industry, with appropriate government regulation.

9.) The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.

10.) The plan should assure consumer representation throughout its operation.

In his statement Dr. Sammons pointed out that the AMA agreed with the need to restrain increases in the cost of care and to control the inflationary impact of any program considered by Congress — but that careful consideration must be taken that quality and access to care were not adversely affected. He also touched upon the AMA's participation in the voluntary effort program and AMA President Tom E. Nesbitt's call for physicians to limit fee increases.

"Understandably," Dr. Sammons said, "in the absence of a specific legislative proposal, it is difficult to

comment in greater detail. For example, we have reservations about a reference to the need for a major reform of the health system without better understanding the details of that reform.

"During the NHI debate, we would urge the private sector to continue to work to expand private health insurance availability and coverage, to maintain quality of care, and to voluntarily restrain the cost of care."

\* \* \*

After more than two months of bitter struggle within seesawing House Commerce Committee the Administration's hospital cost control bill has suffered a rippling and probably fatal blow.

The House Commerce Committee has stunned the Administration by voting 22 to 21 to remove the threat of federal controls from its measure. The committee then approved 15 to 12 a substitute bill asking hospitals to cut revenue increases by two percent a year and also establishing a Presidential Commission to oversee the situation. States would receive financial aid for their own cost control programs if they wish.

Health, Education and Welfare Department Secretary, Joseph Califano, said the committee action was a defeat for the public interest and a victory for the special hospital interests." He told a news conference he will talk to Congressional leaders "to assess our ability to obtain a meaningful bill from Congress this year." If this can't be done, he said, the Administra-

tion "will have to take its case to the people and come back next year with a strong proposal."

Even before the committee's vote, the Hospital Cost Containment Act faced rough sledding in Congress, requiring clearance from the House Ways and Means Committee and the Senate Finance Committee where resistance to the concept was strong. The key Commerce vote was believed by most people to kill the bill for this session.

A bitter Califano said the Administration has "lost to a very strong and effective lobby." Health provider groups, led by the American Medical Association, the American Hospital Association and the Federation of American Hospitals, were in the forefront of the drive to block the bill.

Commenting on the committee's action, Robert B. Hunter, M.D., AMA Board Chairman, said the AMA "is pleased to learn that the efforts of the private sector, through the voluntary effort and other cost consciousness programs, has been recognized by Congress. This kind of coordinated and cooperative effort between physicians and hospitals to cut the rise in the escalation of health care costs is the only responsible approach to the continued delivery of quality health care."

Recent statistics revealed that the voluntary effort of the AMA, the AHA and the FAH was helping keep hospital cost increases down this year to a rate which makes achievement of the two percent goal likely. This may have proved a factor in the Commerce

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Committee vote on the substitute bill offered by Rep. James Broyhill (R.-N.C.). Even Rep. Paul Rogers (D-Fla.), Chairman of the Health Subcommittee and champion of the Administration's cause on this issue, voted for the substitute, saying we had "to get this matter out of Committee . . . let's get it to the floor and let the members vote their conscience there."

Earlier, the Administration had been forced to swallow a major compromise — a provision giving the private sector an opportunity to decrease the rate of inflation before allowing establishment of mandatory federal ceilings on hospital's annual expenditures; these controls were nullified by the crucial 22-21 Commerce vote.

Secretary Califano, the Administration's chief spokesman, had maintained a steady barrage of invective at hospitals, declaring they are "obese" and suffering from "runaway cost inflation."

Later, Michael Bromberg, FAH Executive Director, said Califano had "deliberately misled the public when asked about the House action on the Hospital Cost Containment Bill."

Bromberg said Califano cited figures on profits for the entire hospital industry and stated they were just for investor-owned hospitals. Califano's statement on television news amounted to a "cabinet officer shooting from the hip with deliberately misleading information," said Bromberg.

Bromberg also said Califano "has impugned the integrity of some of the most outstanding members of

Congress by saying the House Commerce Committee sold out to lobbyists."

"The Secretary refuses to admit that the Committee rejected the bill because it was a bad piece of legislation," Bromberg said.

The Administration now pins its dwindling hopes for a hospital cost control bill on a possible Senate floor fight.

Following the defeat of its plan by the House Commerce Committee, the Administration suffered another major setback when the Senate Finance Committee tentatively approved its own long-pending measure for changing Medicare-Medicaid hospital reimbursement. None of the Administration-sought changes to broaden the plan was included.

An attempt could be made when the Finance Committee bill reaches the Senate to insert the hospital revenue ceiling of the Administration, but the struggle would be close and the issue appears dead in the House.

\* \* \*

The Senate has approved a scaled-down measure continuing federal aid for Health Maintenance Organizations (HMOs).

Reports of abuses of the HMO program in some areas led the Senate to adopt financial disclosure provisions and other rule tightening. As cleared by the Senate, the HMO program would be extended for three years with a total authorization of \$170 million

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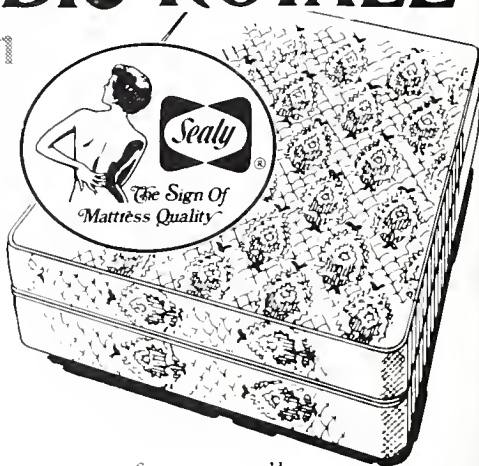
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The original request had been for a five-year extension and \$400 million.

There was only one dissenting vote on final passage — by Sen. Carl Curtis (R-Neb.), who said efficient IMOs don't need subsidies and there are "too many instances of fraud and abuse among subsidized IMOs. . . ."

A provision exempting HMOs from certificate of need requirements under planning programs was dropped from the bill and was scheduled to be taken up later when the planning bill comes to the floor.

Sen. Sam Nunn (D-Ga.), chairman of a special Senate investigations subcommittee, held hearings and issued a report this year criticizing past operations of the HMO program and pointing to instances of abuse and inefficiency. He led a successful drive to increase the size of the bill and to include some of the anti-fraud provisions, securing agreement with Sens. Edward Kennedy (D-Mass.) and Richard Schweiker (R-Pa.) on the limiting proposals in advance of the Senate vote.

Speaking in favor of the bill, Sen. Robert Dole (R-Kan.) said that "unless we monitor much more closely what we have been doing, we may be supporting a program which could rival the nursing home and Medicaid Bill scandals about which we have already heard all too much."

The measure, which now goes to the House, would increase the maximum grant, or loan guarantee, for an initial HMO project from \$1 million to \$2 million,

would allow twice as much in aggregate initial operating loans and guarantees to be outstanding (\$5 million, up from \$2.5 million), relax certain benefit requirements, and establish a HEW Department system to police the program.

\* \* \*

A dramatic decline in hospital inflation has "clearly demonstrated that the private sector" can handle the task of curbing rising costs, said James Sammons, M.D., AMA Executive Vice President.

Dr. Sammons and other officials connected with the voluntary effort (VE) told a Washington, D.C., news conference that April figures revealed that for the eighth consecutive month the rate of increase in hospital expenditures has fallen.

The private sector "can be proud" that the threat of federal hospital cost controls has not "affected the cost of care one whit," Dr. Sammons said.

"The quality of care continues to be the best in the world," he said.

John Alexander McMahon, AHA President, said the figures demonstrate that the voluntary effort "is alive and well." He said the key to the success has been that hospitals and physicians have been able to approach the problem of cost increases in a way most appropriate for each institution involved.

Michael Bromberg, FAH Executive Director, said the voluntary effort is "well ahead of schedule." Bromberg praised the AMA for helping to make



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physicians "more cost conscious."

The voluntary effort, led by the AMA, AHA and FAH has a goal of reducing the rate of increase in hospital expenditures by two percent a year for the next two years. Hospital costs rose 15.6 percent last year. For the first four months of this year the annual rate of increase was running at only 12.7 percent, well within the desired two percent drop.

Resentment was expressed at the Justice Department's failure to give the VE a clear green light for antitrust exemption for its voluntary activities. However, the officials noted that Justice has given no indication that any of VE's activities will face legal challenge from the government.

The statement of the HEW Department to Justice opposing antitrust clearance for the VE was criticized as a "purely political move," by Dr. Sammons.

Bromberg added that "we would have been able to move a lot faster if HEW had offered any help. period." McMahon said Secretary Califano continues to make charges about hospital costs "running wild" despite the progress that has been made in the past several months.

Results of a voluntary effort survey showed that 37 states are currently conducting provisional certification programs in their community hospitals with most of the remaining states expected to begin such programs within a month. Provisional certification involves commitment of hospital boards, management, and medical staffs to the state-level voluntary efforts to adopt cost containment principles and programs in their institutions and to provide various data to the state committees to monitor rates of increase.

\* \* \*

The government's \$200 million Neighborhood Health Center program is overstaffed, the General Accounting Office (GAO) has charged.

The GAO, which investigates federal programs for Congress, said the "underuse of physicians, dentists, support personnel and services is costing the six centers to date investigated more than \$1 million annually."

The HEW Department operates 112 Community Health Centers primarily in urban areas. GAO said the annual salary costs for excess primary care physicians at the centers is above \$4 million. Costs for excess supporting staff were estimated to be \$6.3 million.

At 58% of the centers, the average number of patients treated by physicians per hour fell below HEW's minimum standard of 2.7 per hour, according to GAO.

In a report to Congress, GAO said anticipated patient demand on which staff levels were originally

based has not materialized, and staffs have not been reduced to levels consistent with demand.

Demand for health services from the neighborhood health centers is not likely to increase beyond present levels and could decline because the population growth of the areas that the centers serve has either stabilized or other sources of health care have become available, the report said.

\* \* \*

The government has issued rules under which federal funds may be used to pay for Medicaid abortions.

The two physicians who certify necessity of the abortion must be financially independent of each other to eliminate conflicts of interest. Under law, federal funds may be used for abortions only when two physicians certify the mother will suffer severe and long-lasting damage.

The name and address of both the victim of rape or incest and the person reporting the crime must be listed. The law allows federal money for abortions in cases of rape or incest if the crime is reported to the police or public health officials within 60 days. Previous regulations did not require the address of the victim.

When physicians certify that the mother's health would be affected without an abortion, the name and address of the patient must be given to state and federal authorities.

The HEW Department said the address requirements will enable HEW and state officials "to ascertain the appropriateness of payments for abortions."

\* \* \*

Hale Champion, second-most powerful official at the HEW Department, is in line to be Social Security Commissioner. Currently HEW Undersecretary, the 55-year-old Champion brings a long background of financial experience to the post which has been vacant since the first of the year.

Though on the surface a demotion for Champion, the Social Security Directorship has traditionally been a major federal position, its occupant controlling a vast financial operation in government — the disbursing of hundreds of billions of dollars of retirement, Medicare, unemployment, disability and other funds.

Reportedly in line for Champion's position under HEW Secretary, Joseph Califano, is 46-year-old Stanford Ross, a tax lawyer and long-time friend of the secretary. Ross is chairman of the Social Security Advisory Council.

Champion was California Finance Director in the 1960s and served for six years as Financial Vice President of Harvard University.



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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

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- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
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- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications and Usage:** For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

**Also for the treatment of documented *Pneumocystis carinii* pneumonitis.** To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37, 20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

**Warnings:** Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage:** Not recommended for infants less than two months of age.

**Urinary Tract Infections:** Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose<sup>®</sup> packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose<sup>®</sup> packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see back cover.



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Please see reverse side for summary of product information.

# NORTH CAROLINA

## *Medical Journal*

The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY □ □ □ October 1978, Vol. 39, No. 10

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**CURRENT CONCEPTS: Management of Breast Cancer:** Hyman B. Muss, M.D., Douglas R. White, M.D., Frederick Richards, II, M.D., M. Robert Cooper, M.D., John J. Stuart, M.D., and Charles L. Spurr, M.D.

**Perforation of a Benign Gastric Ulcer into the Left Pleural Cavity: Successful Surgical Treatment of a Case Mimicking Boerhaave's Syndrome:** Norman A. Silverman, M.D., and E. Wilson Staub, M.D.

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1979 Committee Conclave  
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

**Side Effects:** Drowsiness, confusion, diplopia.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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**The Avis Incremental Discount Card/Sticker identification was enclosed with the October "Bulletin." If you did not receive your A.I.D. card/sticker, it is suggested that all members immediately write the North Carolina Medical Society A.I.D. number A/A 6012 00 on the front of their North Carolina Medical Society membership card, or contact the Medical Society Headquarters Office, P.O. Box 27167, Raleigh, N.C. 27611.**



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October 1978, Vol. 39, No. 10

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**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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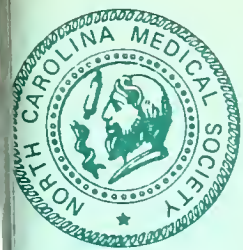
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# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

No. 5

October 1978

The Annual Society Committee Conclave was held in Mid Pines, N.C., from September 27th-30th and the Executive Council met on October 1, 1978. Forty of our committees held meetings which were well attended with much interest and enthusiasm. In behalf of the Society, I would like to thank the Executive Council, Commissioners, Committee Chairmen, and members of the various committees for giving their time and talents in making this a successful Conclave.

The Executive Council elected T. Tilghman Herring, M.D., general surgeon, Wilson, as the Society's new Second Vice-President. Albert Stewart, M.D., Fayetteville, had been elevated to First Vice-President. Dr. Herring is at present a Commissioner and has been for many years Chairman of the Finance Committee. He has devoted many years of dedicated and faithful service to the Society and it will be a pleasure to have him serve as the Second Vice-President.

Mrs. Mary Jane Means, Auxiliary President, reported total contributions for AMA-ERF last year were \$21,643.90 with 75% contributed through the Sharing Christmas Card Project. This is an increase of almost \$5,000 over last year. Mrs. Means was present at the dedication of the Buncombe County Health Adventure with Mrs. Rosalyn Carter as guest speaker. This is a magnificent health education facility that will enable school children throughout the western area to learn more about their bodies and how to care for them properly.

The Council voted to combine the Committee on Drug Abuse and the Committee on Pharmacy. The Committee on Legislation and the Committee on Communications will be established as free-standing committees. They also voted to establish a Committee on Ethics and Religion. It was decided that any resolution to the House of Delegates from a county society should bear the signature of two officers from that county society.

A resolution was passed that the North Carolina Society of Ophthalmology in cooperation with the North Carolina Medical Society introduce legislation in the North Carolina Legislature for the purpose of repealing the 1977 Optometry Drug Use Law. The Council decided that initial certification or recertification by a Specialty Board is sufficient documentation of completion of continuing medical education requirements for a three-year period. The Council voted that the Society recommend to North Carolina medical institutions that "retired and disabled" physicians be admitted to continuing medical education courses without tuition fees and endorsed the concept that the Committee on Medical Education will contribute basic science articles for publication in the North Carolina Medical Journal.

The format of the Annual Meeting for 1979 has been changed with the sessions beginning on Thursday morning and ending Saturday night. The golf and tennis tournaments will be reinstituted.

The Committee on Cancer would like to emphasize to Society members that North Carolina law requires the reporting of cancer deaths to the local Health Department. They also urge each doctor to read carefully the recently mailed publication of the Department of Vital Statistics about Death Certificates.



The Committee on Medical Cost Containment voted to write a letter to the Chairman of the Audit Committee and President of the Medical Staff of each hospital in the state requesting the Hospital Administrator to provide a copy of a patient's bill to each doctor once a month.

The Committee on Traffic Safety recommended that the Society go on record as favoring the concept of reviewing and rewriting the current laws involving drunken drivers.

The Committee on Child Health recommended that routine screening of newborns for hypothyroidism be established as part of the newborn screening program. The Council voted to recommend to the State Health Department the continued serology test for marriage licenses, but requested the abolishment of the rubella testing requirement of G.S. 51-9 by the 1979 General Assembly.

The Committee on Chronic Illness recommended the Society work with other organizations to preserve the dignity and peace of the individual in all matters pertaining to death. It was also suggested that the Society endorse the Hospice concept and encourage its members to participate in this specialized approach to the care of the terminally ill patient. This Committee also recommended that medical schools and other institutions devote increased attention in their teaching programs to the special problems involved in the care of terminally ill patients.

The Committee on Drug Abuse recommends that each county medical society plan some dialogue with special emphasis on drug abuse at the local level with representative groups of pharmacists and physicians to discuss issues of common interest.

The Committee on Mental Health feels that the budget recommended by Secretary Sarah Morrow, M.D., for the Division of Health Services is restrictive with cutbacks in funding of services which will seriously threaten the already inadequate medical and psychiatric services of the mental hospitals and mental health centers. Insufficient funding will result in loss of accreditation status by the Joint Commission (JCAH) and put the state mental hospitals at the mercy of the stringent accreditation procedures of HEW. The Council passed a resolution that the Society strongly endorse the work of the Study Commission to revise the North Carolina Commitment Law and its implementation. It was recommended the North Carolina Medical Society go on record in favor of locally based treatment for the seriously mentally ill whenever possible and when such treatment is not feasible, strongly support the provision of high quality care in the regional psychiatric hospitals with assurance of continuity of care between the hospitals and the community services.

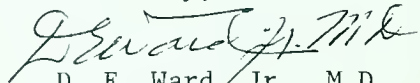
The Medical-Legal Committee is undertaking a study of and the appropriate wording for a surgical consent form for the state.

The Committee on Legislation recommends that the Department of Human Resources be requested to tighten the regulation on the licensing of lay midwives and the committee also reaffirmed its support of the Health Education Bill (No. 540) and for its continued funding by the General Assembly.

The Committee on Eye Care recommended that all reasonable effort be made to see that a code for permission for donation of eyes or other human tissue be made an integral part of the North Carolina Driver's License.

Additional items from the October 1 Executive Council meeting will be reported in the November President's Newsletter.

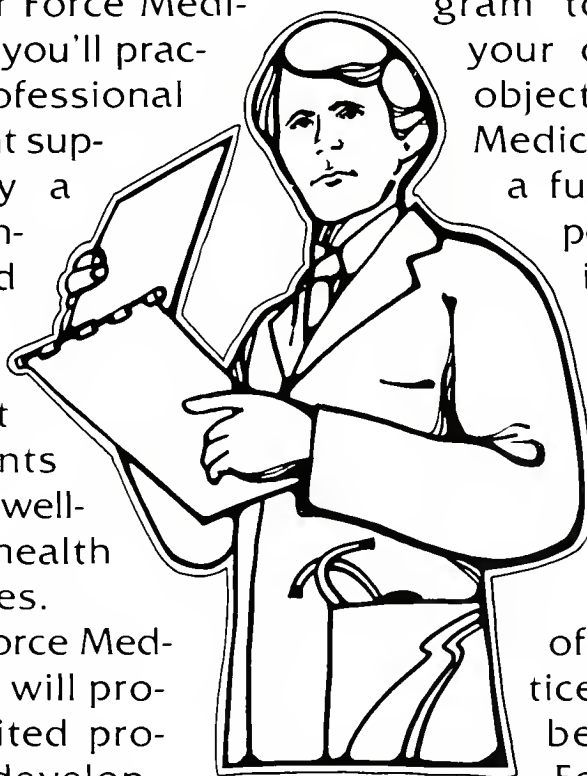
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D. E. Ward, Jr., M.D.  
President

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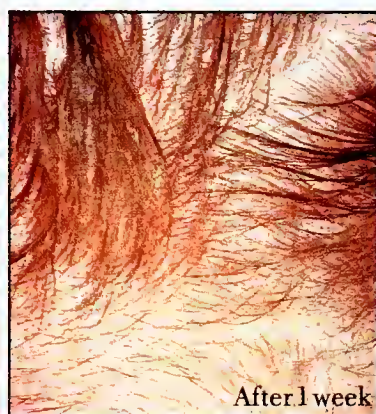


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**Usage in Pregnancy**—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been

associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

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Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

**ADVERSE REACTIONS:** The following local adverse reactions have been reported with topical corticosteroid especially under occlusive dressings: burning sensation, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

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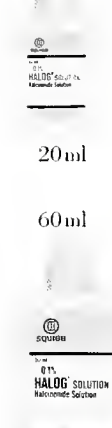
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Among the contributions made to the Foundation since its inception have been:

- The Forsyth-Stokes Medical Auxiliary Benevolent and Educational Fund in 1971, and
- the assets of the Joseph Ward Hooper, Sr., Trust which were transferred to the Foundation in 1976.

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**Usage in Pregnancy:** Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical

steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

**PRECAUTIONS:** Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not promptly obtained, discontinue the preparation until adequate control by other means is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

**ADVERSE REACTIONS:** Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

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# Current Concepts: Management of Breast Cancer

Hyman B. Muss, M.D., Douglas R. White, M.D.,  
Frederick Richards, II, M.D., M. Robert Cooper, M.D.,  
John J. Stuart, M.D., and Charles L. Spurr, M.D.

## INTRODUCTION

**B**REAST cancer remains one of the most challenging problems in oncology. In the past, treatment was usually in the domain of the surgeon. It has become increasingly apparent, however, that most of the morbidity and mortality resulting from breast cancer are due not to problems with locally recurrent disease but to distant metastatic disease.

## PREOPERATIVE EVALUATION

Careful evaluation is necessary in any patient with a mass in the breast suggestive of cancer. Clinical evaluation and mammograms are likely to suggest the correct diagnosis in more than 90% of patients. A complete blood count, urinalysis, and complete chemistry profile should be obtained and renal and liver functions tested. The chemistry profile may indicate hypercalcemia or a liver function abnormality, suggestive of more advanced disease. A chest x-ray, routinely obtained on all patients, may reveal operable disease. Most on-

cologists would consider a bone scan of value since it is much more sensitive than conventional bone x-rays and may demonstrate disseminated lesions.<sup>1</sup> Spot films should be obtained of all suspicious or positive areas on scan to attempt to rule out benign processes that may account for these abnormalities (e.g. fracture, osteomyelitis, degenerative disease). Up to 40% of patients with clinical Stage I and II disease have positive bone scans<sup>2,3</sup> and biopsies of these lesions may reveal metastatic disease.<sup>4</sup>

A liver scan in a patient with normal serum alkaline phosphatase and a nonpalpable liver usually will be negative.<sup>5</sup> In certain situations a liver scan may be indicated but this test is usually not worth its high cost. Certainly any patient with liver function abnormalities or a palpable liver should be studied before surgery. One must be aware that a positive scan showing an enlarged liver with patchy infiltrates but without focal defects is frequently not associated with malignancy.<sup>6</sup> A patient should not be denied a chance for surgical cure on the basis of nonspecific findings on a liver scan. Brain scanning is unlikely to be of value in asymptomatic patients with early breast

cancer.<sup>7</sup> Computerized brain and body scans may prove to be of value in these patients but their role in improving data from simpler and less costly tests has yet to be defined.

Tumor markers, such as the carcinoembryonic antigen (CEA), as well as several new proteins and enzymes, may assist follow-up evaluation of patients with breast cancer. Presently, however, these have a limited role in daily clinical practice. A baseline CEA may be of help in evaluating the results of surgery but false positives and negatives are common with this tumor marker and only in unusual situations would it be reasonable to make important clinical decisions based on these results alone.

## PRIMARY THERAPY

In spite of many years experience with various types of therapy, the best method of handling the primary tumor in a patient with breast cancer has yet to be defined. Recent studies appear to show no difference between radical mastectomy, radical mastectomy with radiation therapy, simple mastectomy with radiation therapy, and simple mastectomy alone in terms of length of survival.<sup>8</sup> Differences in the type of primary therapy do relate to the tendency for local recurrence and to

From the Oncology Research Center and Department of Medicine of the Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, N.C. 27103. This paper was presented in part at the 123rd Annual Meeting of the North Carolina Medical Society at Pinehurst, C., May 6, 1977. Reprint requests to Dr. Muss.



the difficulties encountered in treating local recurrence if it appears after initial therapy. It is of note that about 80% of patients who have local recurrence as the first manifestation of metastatic disease also have distant metastases at the same time.<sup>9</sup> Although there is no question that local recurrence can cause pain, cosmetic problems and considerable anxiety, it is unusual for it to cause substantial morbidity and it rarely results in the death of the patient. Radical or modified radical mastectomy alone or less radical procedures associated with adjuvant radiation therapy appear most effective in preventing local recurrence. Simple mastectomy alone is associated with up to 30% local recurrence,<sup>10</sup> although in most instances treatment at the time of recurrence is successful.<sup>11</sup> Theoretically, adjuvant chemotherapy, which will be discussed below, if effective at all, should prevent local as well as distant recurrence.

Radical mastectomy and modified radical mastectomy, in addition to being therapeutic, also provide the physician with important prognostic information. The TNM staging system for breast cancer,<sup>12</sup> based on the size of the tumor (T), the presence of apparent axillary lymph node metastases (N), and whether there is clinical evidence of extranodal metastatic disease (M), is inaccurate in a substantial number of patients. Twenty-six percent of patients with clinically negative axillary examinations will have microscopic nodal involvement at the time of surgery while up to 55% of patients with palpable nodes will be found to have only benign reactive changes.<sup>13</sup> Such data are of critical prognostic importance to both patient and physician. In the first instance, positive microscopic nodal disease indicates a less favorable prognosis than the staging system would indicate. In the second instance, certain types of reactive changes, notably sinus histiocytosis or lymphocytic infiltration, may indicate a more favorable prognosis.<sup>14</sup>

#### ADJUVANT CHEMOTHERAPY

Clinical trials are under way to see if chemotherapy can prevent re-

currence and ultimate mortality from breast cancer in patients who have no clinical or laboratory evidence of residual disease after primary therapy. Several studies are in progress and preliminary results are encouraging.<sup>15,16</sup> These studies have generally been confined to high-risk patients, that is, women with axillary node involvement. The patients are treated with chemotherapeutic agents within several weeks of surgery and usually for one to two years, or until recurrence. The survival rate in women with breast cancer with four or more positive axillary nodes is only 20%-25% at 10 years compared to a survival rate of 70%-80% in women with no axillary node metastases.<sup>17</sup> The survival of women with one to three positive nodes ranges between these extremes. Present chemotherapy trials use single agents, e.g., melphalan,<sup>15</sup> or multiple drugs in combination.<sup>16</sup> Recent reports, some of which have appeared since the Pinehurst meeting, indicate that the only statistically significant differences have been in premenopausal women.<sup>18-19</sup> Combination therapy, which in the treatment of patients with advanced disease is superior to single agent therapy, has produced discouraging adjuvant results in postmenopausal women in European trials.<sup>19</sup> Preliminary data from United States trials suggest that this therapy may still be of value and final results are pending. It is the opinion of most oncologists that high-risk patients should be placed in a controlled protocol if they are to receive adjuvant therapy. Only by this means can significant data be obtained. The preliminary data should be viewed with cautious optimism and one should be aware that none of the current studies has been in progress long enough to determine the long-term value of adjuvant chemotherapy. Preliminary reports of early studies using prophylactic castration, thiopeta administration at the time of surgery, and other adjuvant chemotherapies were often impressive but, ultimately, significant reduction in mortality from disease in 5- and 10-year analyses has not been shown.

#### ESTROGEN RECEPTORS

In the last several years, assay of estrogen receptor protein (ERP), a cytoplasmic estrogen-binding protein found in some malignant breast cancer cells, has proved helpful in predicting the response to hormonal therapy. These assays are available in many commercial laboratories in North Carolina and should be routinely performed as a recognized and justifiable addition to the evaluation and management of the patient with breast cancer. The assay requires a cubic centimeter of rapidly frozen unfixed tumor tissue best obtained at the time of primary surgery because metastases are often not accessible for biopsy. It has been shown that when the ERP is found in the primary tumor, it is usually also demonstrable in subsequent metastases. The converse is also true. Thus, obtaining these data at the time of primary surgery and recording them in the patient's record can be of great help. In patients whose tumors are estrogen receptor positive, 50%-60% will respond to the appropriate hormonal manipulation whether additive or ablative. In those patients whose tumors lack the ERP, fewer than 10% will respond to any type of hormonal therapy.<sup>20</sup> Knowledge of ERP negativity may thus spare an ill patient a surgical ablative procedure or an unsuccessful trial of additive hormonal therapy and allow prompt initial treatment with chemotherapy. Whenever feasible metastatic tumor should also be submitted for receptor assay since it has been reported that in 38% of patients, the ERP activity of subsequent metastases has differed from that of the primary tumor.<sup>21</sup> Recently, progesterone receptor have also been demonstrated in breast cancer tissue. Preliminary data indicate that when estrogen and progesterone receptors are present in the tumor, the likelihood of response to hormonal therapy is as great as 67% while when estrogen receptor protein is positive and progesterone receptor is negative the chance of response is only 39%.<sup>22</sup> The progesterone receptor assay is available at some institutions and will probably become

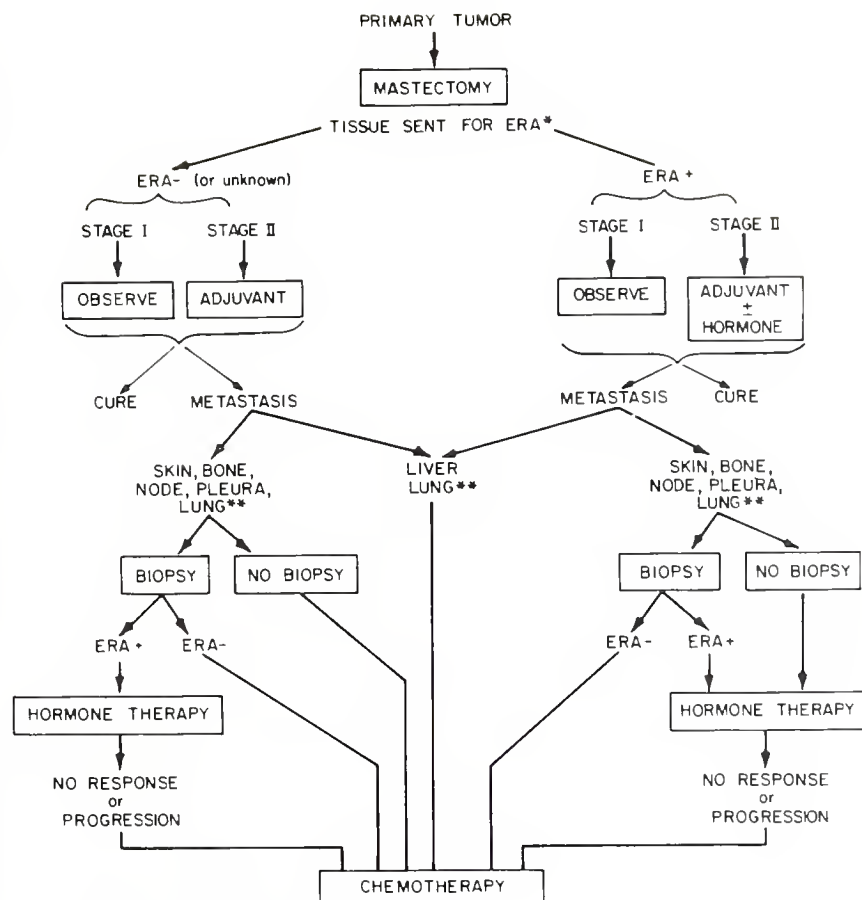
commercially available in the near future. Patients who possess the ERP appear to have a better outlook which is independent of prognosis based on nodal involvement, age, menopausal status, or other predictive factors.<sup>23</sup>

Lastly, in women who have metastatic carcinoma where the primary tumor is not clinically apparent, estrogen receptor assay of the metastatic tissue may help determine the site of the primary tumor. In patients who demonstrate the ERP, it is highly likely that the tumor is of breast origin and hormonal manipulation might play a role in their management. Endometrial and ovarian carcinoma may contain estrogen receptors but clinical evaluation should be sufficient to exclude these lesions in most patients.

### ADVANCED DISEASE

Regardless of their response to hormonal therapy, almost all patients with recurrence will eventually suffer progression of disease. Combination chemotherapy has become valuable for patients with advanced breast cancer. More than 50% of patients treated in this manner have objective responses,<sup>24</sup> 10% to 20% of which are complete. Although the average response lasts from nine months to a year, some patients have remained in remission for over two years. Thus, a small proportion of patients with advanced breast cancer treated with chemicals will be long-term survivors. In addition, chemotherapy of value in the control of extensive pulmonary and hepatic metastases which do not usually respond to hormonal therapy. Extensive studies with combination chemotherapy in breast cancer at this institution have yielded similar results.<sup>25</sup> Many oncologists now believe that chemotherapy is preferred initially for patients with rapidly progressive metastatic disease, especially where there is hepatic or extensive pulmonary involvement and particularly for patients who are estrogen receptor negative or when estrogen receptor assay is not obtainable.

Patients with brain metastases



\*ERA = ESTROGEN RECEPTOR ACTIVITY

\*\*LUNG = LUNG METASTASES MAY RESPOND TO HORMONE THERAPY BUT, IF EXTENSIVE, CHEMOTHERAPY SHOULD BE GIVEN EARLY

Fig. 1. Schema for therapy of the patient with breast cancer.

represent a unique problem. They usually have clinical signs and symptoms indicating CNS involvement and conventional radionuclide brain scans will usually demonstrate intracranial lesions. When scanning is unrevealing despite signs and symptoms, computerized axial tomography should be considered. The administration of corticosteroids in high dose, a valuable adjunct to definitive therapy, should, if possible, be withheld until the studies are complete since prior or concomitant administration may cause false negative scans. After the diagnosis has been confirmed, whole brain irradiation is begun and corticosteroids should be administered concurrently because alleviation of signs and symptoms usually occurs within 24 to 48 hours after they are started. In general, cancer chemotherapeutic agents cross the blood-

brain barrier poorly. The administration of nitrosoureas, high dose methotrexate with citrovorum rescue, or 5-Fluorouracil which will reach the central nervous system may be considered in the future management of these patients. Whole brain irradiation can significantly improve a patient's performance and corticosteroids can be tapered and ultimately discontinued. Most patients will benefit from this therapy and several of our patients have remained free of symptoms with normal brain scans from one to two years after treatment.

Radiation therapy can provide effective palliation in patients with advanced disease; for example, symptomatic bony metastases or chest wall recurrence. One must be aware that radiation therapy causes bone marrow suppression, especially when the pelvis, ribs and



spine are treated, and can limit concomitant or subsequent chemotherapy. In patients with large osteolytic lesions of the femur, orthopedic evaluation should be considered because pinning or hip replacement may be of benefit especially if a fracture has occurred.

## CONCLUSIONS

In light of our knowledge of the result of assay of estrogen receptors done on a specimen obtained at primary surgery, a therapeutic schema is presented (Fig. 1). All pathological Stage I patients are observed while all Stage II patients should be considered for adjuvant therapy. If a patient develops metastatic disease, further therapy is determined by the initial estrogen receptor assay results unless the recurrent tumor is accessible to biopsy. If biopsy of the recurrence can be obtained, estrogen receptor assay is repeated since in some patients the estrogen receptor status may change from the time of primary surgery. A change from ERA positivity to ERA negativity may indicate that the tumor is less well-differentiated and portend a poorer prognosis. In patients with predominantly soft tissue or bone metastases, or with pulmonary disease — small pleural effusion or small nodules without compromise of pulmonary function — hormonal therapy would be the first choice for those who have estrogen receptor protein demonstrated in the tumor.

In patients with extensive pulmonary metastases or a large pleural effusion with compromised respiratory function, chemotherapy would be preferred. In patients with extensive liver metastases, we would suggest chemotherapy regardless of hormonal status since few respond to hormonal manipulation. Patients with brain metastases should be managed separately as noted above.

Local irradiation can be effectively used for patients whose recurrent disease can be encompassed within reasonable portals and whose previous therapy does not preclude further irradiation. Chemo- or hormonal therapy should be considered after radiation therapy for many of these patients, especially if there is disease outside the irradiated field.

## ADDENDUM

Since the presentation of these data, several studies have appeared indicating that preoperative bone scans are positive in only a very small percentage of patients. It is still our feeling that they should be done prior to surgery as they will detect some patients with occult metastatic disease.

## Acknowledgment

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... by an inconsiderate and childish affectation of Noveltie, as is the true case of the first invention of Tobacco taking, and of the first entry thereof among us. For Tobacco being a common herbe, which (though under divers names) growes almost everywhere, was first found out by some of the barbarous Indians, to be a Preservative, or Antidot against the Pockes, a filthy disease, whereunto these barbarous people are (as all men know) very much subject, what through the uncleanly and adust constitution of their bodies, and what through the intemperate heate of their Climate: so that as from them was first brought into Christendome, that most detestable disease, so from them likewise was first brought this use of Tobacco, as a stinking and unsavorie Antidot, for so corrupted and execrable a Maladie, the stinking Suffumigation whereof they yet use against the disease, making so one canker or venime to eate out another. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Perforation of a Benign Gastric Ulcer Into the Left Pleural Cavity: Successful Surgical Treatment of a Case Mimicking Boerhaave's Syndrome

Norman A. Silverman, M.D., and E. Wilson Staub, M.D.

**ABSTRACT** A case of perforation of a benign gastric ulcer into the left pleural cavity is reported. Perforation of a gastric ulcer into the thoracic cavity is usually due to delay in diagnosis and treatment of an intra-abdominal gastric perforation or an intrathoracic location of the stomach. Prompt surgical treatment is imperative.

IN 1724, Boerhaave described the clinical syndrome of postmetic rupture of the esophagus. The resultant contamination of the mediastinum and left pleural cavity by gastric contents classically produces excruciating chest or epigastric pain, dyspnea and subcutaneous emphysema. The differential diagnosis includes dissection of the thoracic aorta, acute myocardial infarction, pulmonary embolism, spontaneous pneumothorax, incarcerated diaphragmatic hernia, and such acute abdominal diseases as perforated peptic ulcer, pancreatitis, mesenteric vascular occlusion and biliary colic. This report describes a patient who was thought to have spontaneous rupture of the esophagus but who was found at

surgery to have free perforation of a benign gastric ulcer into the left pleural cavity with no intraperitoneal soilage.

## CASE REPORT

A 77-year-old woman was admitted to Moore Memorial Hospital after fracturing her right femoral neck. Her history revealed that a permanent transvenous pacemaker had been inserted two years earlier for complete heart block and that she had a long history of osteoarthritis for which indomethacin had been prescribed. On the day of admission, open reduction and internal fixation of the right hip with a Knowles pin was performed. On the second postoperative day, she became nauseated and vomited and then began to complain of severe pain in her left chest and shortness of breath. The patient was tachypneic and dyspneic with a respiratory rate of 32 and a temperature of 101°. No subcutaneous emphysema was found. Breath sounds were markedly diminished over the left chest. The abdomen was nontender and bowel sounds were normal. Blood studies showed a leukocytosis of 21,700 and normal serum chemistries. The electrocardiogram demonstrated a paced rhythm with no change from the preoperative tracing. Chest x-ray showed a left hydropneumothorax and a #20 argyle chest tube was inserted that

drained bilious fluid with a pH of 4.0 (Fig. 1). An emergency gastrografin swallow was interpreted as demonstrating no esophageal perforation (Fig. 2). However, charcoal given by mouth soon appeared in the thoracostomy tube. The patient was taken to the operating room with the presumptive diagnosis of postmetic esophageal perforation and explored through a left posterolateral thoracotomy. The lung was encased in a fibrinous exudate and the pleural cavity contained a large quantity of undigested food. After evacuation of the particulate matter, gastric mucosa was visualized through a 1 cm perforation in the dome of the left diaphragm. The diaphragm was radially incised. Abdominal exploration revealed no peritoneal contamination; however, the fundus of the stomach was densely adherent to the diaphragm. When the stomach was freed, a peptic ulcer was found in the fundus. The ulcer was excised and the site oversewn in two layers. Histological examination confirmed the diagnosis of a benign gastric ulcer. At surgery, no evidence of esophageal perforation was found. The patient did well. Her chest tubes were removed on the fifth day and she was discharged on the 16th postoperative day.

## DISCUSSION

Perforation continues to be a

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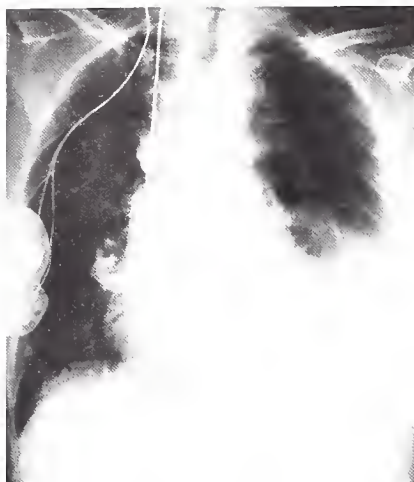


Fig. 1. Initial chest film demonstrates left hydropneumothorax.



Fig. 2. Gastrografin swallow shows no extravasation of contrast medium from the esophagus.

major complication of peptic ulcerations of the stomach. Most benign gastric ulcers appear on the lesser curvature of the stomach at the junction of the antral and fundic mucosa. Transmural penetration therefore results in free perforation into the peritoneal cavity with the classic symptoms of sudden abdominal pain, rigidity and peritonitis. Unusual clinical presentations of perforated gastric ulcer may occur because of a delay in making the diagnosis or because of an atypical location of the ulcer. It has been recently appreciated that certain medications can produce chronic ulceration, particularly in women. An important and interesting feature of these drug-induced ulcers is their tendency to localize in the fundus and body of

the stomach along the greater curvature.<sup>1</sup> Indomethacin is a known ulcerogenic drug, and its use by the patient described in this report may be invoked as etiologic for the chronic ulcer found at surgery in the gastric fundus. Inflammation around the ulcer would then cause dense adherence to the adjacent diaphragm. When perforation occurred, the peritoneal cavity would be walled off by the previous scarring and the ulcer would rupture transdiaphragmatically into the free pleural space.

In a review of the literature, it is apparent that the involvement of the mediastinum and pleura by perforated gastric ulcers is often due to delay in establishing the correct diagnosis of an intra-abdominal gastric perforation. Fenwick collected 21 cases of perforated gastric ulcer into the left pleura, mediastinum, heart or pericardium.<sup>2</sup> In these cases, subdiaphragmatic abscess antedated diaphragmatic perforation. The stomach was firmly adherent to the inferior surface of the diaphragm, and the diaphragmatic muscle was finally eroded by infection and the chronic ulcer. Friedenwald described a patient whose subphrenic abscess eroded through the diaphragm and adherent pleura into lung parenchyma causing multiple lung abscesses.<sup>3</sup> A patient described by Cooper had a perforated gastric ulcer and was ill for six weeks before perforation of a subphrenic abscess into the lung and pleura with a resultant bronchopleural fistula.<sup>4</sup>

The lethality of acute perforation of an intra-abdominal gastric ulcer into the left pleural cavity is confirmed by previous reports of patients treated without surgery. Hudson et al described a patient who vomited, developed severe abdominal pain and a left hydro-pneumothorax, and died within 24 hours.<sup>5</sup> An autopsy determined that a gastric ulcer on the posterior cardia had eroded superiorly into the wall of the esophagus causing dissection of the esophageal wall with perforation into the left pleural cavity. Wulsin presented a patient who had a two-hour history of abdominal

pain and hematemesis.<sup>6</sup> He presented with subcutaneous emphysema and a left pneumothorax. The patient refused treatment and at autopsy 10 days later was found to have a perforated gastric ulcer, retroperitoneal and mediastinal abscesses, and gastric fluid in the left chest. An autopsy study of 31 cases of undiagnosed perforated peptic ulcer describes a patient with a fundal ulcer perforating into the right pleural cavity.<sup>7</sup>

Perforation by gastric ulcers into thoracic structures may be due to the intrathoracic location of the stomach. Sangster reported a patient who had a diaphragmatic defect in the tendinous portion of the left diaphragm.<sup>8</sup> No hernia sac was present and a benign ulcer in the herniated stomach perforated into the pleural cavity. Similarly, Nigam described a patient with an eventration of the left diaphragm whose gastric ulcer perforated into the left chest.<sup>9</sup> This patient was successfully treated by excising and oversewing the ulcer. After esophagectomy, an esophagogastric anastomosis is often made in the left chest to reestablish gastrointestinal continuity. Ulcers developing in the intrathoracic stomach remnant have been reported to perforate the pericardium causing pericarditis, pyopneumopericardium or cardiac tamponade. In addition, these reports have documented direct perforation by an ulcer of the left atrium or left ventricle resulting in exsanguinating gastrointestinal hemorrhage.<sup>10</sup>

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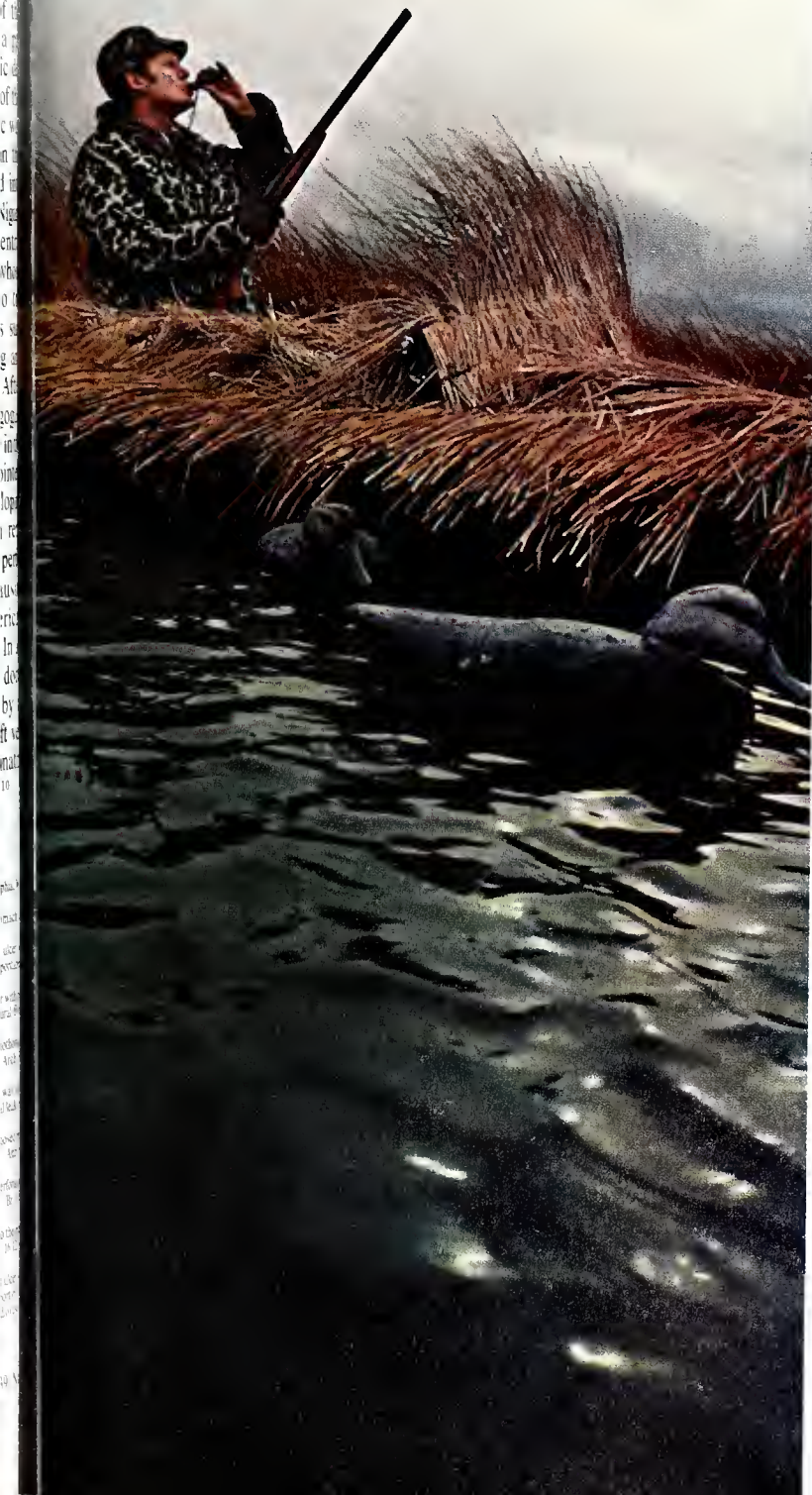
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# Editorials

## ROLE OF NORTH CAROLINA PHYSICIANS IN EMERGENCY MEDICAL SERVICES

Until fairly recently emergency medical services (EMS) were a hodgepodge of ambulances usually based at funeral homes and reluctant emergency room personnel mostly provided by hospitals' house staffs. Federal and state laws have brought some order into this chaos. The operation of emergency vehicles has been concentrated essentially in the hands of the local governments. The state has mandated, provided and controlled the training of emergency medical technicians (EMTs). Some 14,000 people are certified in North Carolina as emergency medical technicians, 300 are certified as EMTIVs (emergency medical technician intravenous) and 100 as mobile intensive care technicians. Emergency medical services have four identifiable components: communication, transportation, medical service and training. The goal of emergency medical services is to provide a person who is injured or suddenly taken ill with rapidly-arriving help, sustenance of life and quick and safe transportation to a medical facility that can adequately care for him. It is obvious that in order to do these things efficiently a proper communication network must exist among the base of operations, the vehicles, the personnel in the field and the emergency departments of hospitals. Transportation vehicles should meet certain federal and state requirements, and to achieve all of the above, training is necessary. The acid test of emergency medical services occurs at the hospitals.

For the past century and a half the physician and the nurse have established working relationships in the course of their practice within the hospital. It is now necessary for physicians to establish some relationship with emergency medical technicians. As much as the new specialty of emergency medicine has produced physicians oriented toward emergency medicine, it is of paramount importance that every physician be cognizant of his role in emergency medical services. After all, anyone involved in an emergency and taken to a hospital is likely to become the patient of a physician on the hospital staff.

In some communities emergency medical services encounter outright hostility from the medical community. Due to the availability of nonphysician instructors, emergency medical technicians are relatively self-sufficient in terms of basic life support techniques. However, training in the administration of intravenous fluids and advanced life support is available only in a hospital. To serve all patients in the best

possible manner, physicians should see that emergency medical technicians and mobile intensive care technicians are properly trained and that they maintain their skills. Therefore, it becomes of great importance that the teaching of these people take place in medical institutions.

Emergency medical technicians are in the process of forming what will likely become a large and important organization. The national group has more than 10,000 members and is publishing a journal; on the state level a young organization is active and running.

The medical profession is often set upon by the critics as unresponsive and self-centered. "Emergency medical services" is currently a popular subject, and continued lack of involvement of some local segments of the North Carolina medical community in EMS training could be misinterpreted by our critics as a lack of commitment rather than apathy, which it probably is.

In addition, the lack of involvement by physicians and particularly the paucity of physician support in some smaller communities, encourages the reluctance of nurses and hospital administrators to support EMS.

The time is at hand when all North Carolina physicians should step forward when requested and provide their support and expertise to improve emergency medical services and, therefore, to serve all patients in the best possible manner.

GEORGE PODGORNÝ, M.D., Winston-Salem, N.C.

## GUIDELINES FOR COMPUTERIZED TOMOGRAPHY

The advent of computerized tomography in American medicine provided a wonderful opportunity for taking sides and there were many sides to be taken. For the large hospital, fearful of losing face, scientific progress and improved patient services had to be considered while governmental agencies, watchdogs of cherished dollars, voiced concern because costs seemed dramatically high. The *Wall Street Journal* even entered the fray on behalf of its version of the free market. Somewhat the potential beneficiaries of improved technology, patients, were not consulted although they had many self-appointed spokesmen. Of course patients could not really speak for themselves because it takes time to accumulate enough data to recognize how new instruments can best be used for them.

What theorists without clinical background failed to realize is that after the introduction of any new diag-

nostic or therapeutic vector there is a hunting and gathering stage during which sufficient data must be accumulated at considerable expense for value of the new tool to be determined. Such is our thirst for novelty that we tend to forget that effective application can't come without precise observation. In this issue of the JOURNAL is a report from the Blue Cross and Blue Shield Subcommittee about computerized tomography in North Carolina which has spent many hours in trying to arrive at a reasonable position about reimbursement for the procedure. It deserves the attention of all North Carolina physicians just as the subcommittee deserves our thanks.

Much of the hoopla could have been avoided had the matter been approached dispassionately. De-

velopment is costly and fair return for investment is essential. However, quality control in the medical marketplace is determined in large measure by utilitarian standards — ultimately by value to patient and physician. Perhaps third parties need to join industry, hospitals, government and physicians in setting up quasi-independent task forces not unlike the team of patient, doctor, drug house and government which evaluates drugs before market. But many drugs are lingering so long in Phase III that other patients are being denied their due. We need ad hoc groups whose recommendations have scientific validity and legal impact if we are to have economy and better medicine. If this is to be done, government must be a partner, not a parent.

J.H.F.

## Committees and Organizations

### COMMITTEE ON TRAFFIC SAFETY "Injury Control"

Every year, 60 million Americans are injured. In 1975 there were 156,000 injury-related deaths; 88,000 hospital personnel and one-eighth of all general hospital beds are required for treatment of the injured. The annual cost of motor vehicle injuries alone is estimated at \$18 billion.

Most injuries are caused by abnormal energy transfers or interference with energy transfers. Abnormal energy transfers include all fractures, lacerations, abrasions and contusions. The causative factor is the transfer of mechanical energy either by moving objects (bullets, knives, etc.) or impacts of moving people against relatively stationary surfaces such as windshields and stairs. Interference with energy transfer includes normal body energy exchanges, such as interference with oxygen exchange, as in drowning or carbon monoxide poisoning, or thermo-regulation, as in freezing. The fundamental tasks in injury are (a) to prevent the agents from reaching people in amounts or rates that exceed injury thresholds, and (b) to minimize the consequences of injury through several approaches:

1. Prevent the marshalling of potentially injurious agents.
2. Reduce the amounts of such agents (limit the speed of vehicles or the height of diving boards).
3. Prevent inappropriate release of the agent (reduce the amount of information a driver must monitor and simplify the actions he must take).
4. Modify the release of the agent (design seat belts which would decelerate the occupants with the vehicle rather than permit more abrupt deceleration against hard surfaces).

5. Separate in time or space.
6. Separate with physical barriers.
7. Modify surfaces and basic structures (remove projections and round and soft corners and edges of likely impact areas such as car fronts).
8. Increase resistance to injury.
9. Emergency response.
10. Medical care and rehabilitation (modern communications systems, ambulances designed and equipped to support life, and highly trained emergency and paramedical personnel are essential for the adequate management of acutely injured patients. Physicians can play a crucial role by being prepared and willing to give life-supporting assistance in emergencies, promoting first-aid training for laymen, pushing for urgently needed services and paramedical training programs, and insisting on the evaluation of medical care of the injured).

Human behavior is undeniably important in injury causation. Behaviors contributing to injury include most human activities. Examples pertinent to drivers include the distance driven, the speed of travel, the use of alcohol, and the non/use of seat belts. "Safety campaigns" have generally been expensive and had little success. Often, the failure of educational efforts has been followed by coercion, and when coercion has failed, legal sanctions have been proposed.

In the area of injury prevention and drugs, alcohol is the only drug involved in a substantial proportion of injury-producing events. Half of all motor vehicle crashes cause fatality to the occupant. More than one-fifth of those in which the occupants are seriously injured and one-third or more of the crashes that are



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fatal to adult pedestrians result at least in part from the use of alcoholic beverages. While medical conditions can contribute to injury events, data are not available for determining the extent to which diseases increase the risk of injury. It is, however, important to note that if injury occurs because a drug was prescribed without adequate warning as to possible side effects, the physician may be held legally liable.

Injuries, the leading cause of death for more than half the span of human life, can be greatly reduced in frequency, severity and sequelae. To do so, physicians, other health workers and the public must employ approaches based on science rather than guesswork. Through relationships with patients and the public and with decision-makers in industry and government, those who understand the issues and scientific concepts involved can effectively contribute to substantial reduction of this huge problem.

WILLIAM HADDON, JR., M.D.

SUSAN P. BAKER M.P.H.

### COMPUTERIZED TOMOGRAPHY SCAN SUBCOMMITTEE OF THE BLUE SHIELD COMMITTEE

#### "Policy Concerning Computerized Tomography Scans"

Blue Cross and Blue Shield of North Carolina, with the help of the Ad Hoc CT Scan Subcommittee of the Blue Shield Committee of the North Carolina Medical Society, has established a policy regarding procedure codes and guidelines pertaining to computerized tomography benefits.

Although Blue Cross and Blue Shield of North Carolina already provides benefits for established diagnostic radiologic tests and procedures consistent with diagnoses, including CT scans, the new policy was created to assure responsible payment of subscriber funds by appropriate and effective usage of this advanced and costly diagnostic service.

In January, 1977, the Blue Shield committee of physicians established the ad hoc CT subcommittee to study the clinical and economic ramifications of CT scans. The subcommittee is composed of the following members:

Edward V. Staab, M.D., Chairman	Nuclear Medicine
Edwin L. Bryan, M.D.	Internal Medicine
David L. Kelly, Jr., M.D.	Neurological Surgery
Robert W. McConnell, M.D.	Radiology
Charles E. Putman, M.D.	Radiology
Robert B. Salmon, M.D.	Radiology
Joseph W. Stiefel, M.D.	Neurology
Robert W. Youngblood, M.D.	General Surgery

This multi-specialty subcommittee met jointly with the Executive Committee of the North Carolina Chapter of the American College of Radiology and conducted discussions with other concerned specialty organizations through the physicians serving on the subcommittee. Blue Cross and Blue Shield of North Carolina established the procedure codes and guidelines of the new policy.

The criteria for benefit payment of the computerized tomography procedures are listed below. These criteria will be changed and updated as addi-

# Librax®

Each capsule contains 5 mg  
chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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\*Librax has been evaluated as possibly effective for this indication.  
Please see brief summary of prescribing information on preceding page.



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sore throat when  
patients want



ional CT scan data are accumulated. When services are provided for other than the indications listed, or for procedures designated "IC" (individual consideration), an explanation should accompany the claim documenting the reasons for CT scan studies.

The subcommittee has developed a CT information form (Form No. L-43) which may be requisitioned from Blue Cross and Blue Shield of North Carolina. It is to be completed by CT scan providers for providing a data base to aid the subcommittee in evaluating effectiveness and the continued updating of indications for scanning. The form, upon completion, should be sent to the North Carolina Medical Society, P.O. Box 27167, Raleigh, N.C. 27611, Attention Subcommittee on Computerized Tomography.

The subcommittee will meet quarterly to review data collected from those seeking reimbursement for CT services as a basis for continued evaluation of the medical indication guidelines and to add criteria for appropriate instrumentation and sequencing with other diagnostic studies.

Also established by the subcommittee is a mechanism for the continuing education of providers with CT capabilities, including regional quarterly meetings for the exchange of technical and diagnostic information, guest speakers to present experiences with CT to other medical groups, and a CT forum at State Medical Society meetings.

The CT scan subcommittee welcomes comments and criticism. Letters should be sent to Edward V.

Staab, M.D., Chairman, CT scan subcommittee, Department of Radiology, North Carolina Memorial Hospital, Chapel Hill, N.C. 27514.

## INDICATIONS FOR CT SCANNING

### *Brain*

#### A. Symptoms

1. Persistent headache of significant magnitude
2. Vertigo
3. Altered consciousness
4. Seizures, excluding febrile
5. Symptoms suggestive of transient ischemic attacks
6. Dementia

#### B. Physical Findings

1. Papilledema, or other signs of increased intracranial pressure
2. Apraxia or aphasia
3. Visual field defects
4. Cerebellar dysfunction signs
5. Hemiparesis
6. Exophthalmos
7. Other focal neurological signs

#### C. Unresolved Medical Problems

1. Vascular
  - a. Cerebral infarction
  - b. Subarachnoid hemorrhage
2. Traumatic
  - a. Hematoma, subdural or intracerebral hematoma

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Charlotte (704) 334-2854

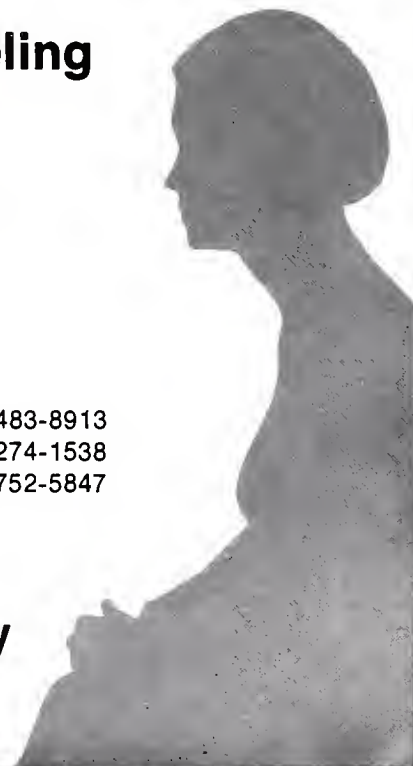
Fayetteville (919) 483-8913  
Greensboro (919) 274-1538  
Greenville (919) 752-5847

Wilmington (919) 763-9727



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of N.C.**

founded in 1903



- b. Orbits
- c. Loss of consciousness or declining neurological status
- 3. Neoplastic
  - a. Primary brain tumor
  - b. Intracranial metastases
- 4. Congenital Lesions
  - a. Hydrocephalus
  - b. Encephaloceles
- 5. Cerebral Deterioration
  - a. Brain atrophy
  - b. Acquired hydrocephalus
  - c. Non-infectious, infiltrative disease
- 6. Infections of central nervous system
- 7. Abnormalities seen on skull x-ray, e.g., calcification
- D. Serial studies to evaluate response to treatment such as:
  - 1. Neoplasm
  - 2. Hematoma
  - 3. Hydrocephalus
  - 4. Brain abscess
- E. Serial studies in patients without structural abnormality
  - 1. Progressive neurological findings
  - 2. Physician justification to peer satisfaction

*Orbits* — Studies for mass lesions.

*Face* — Studies to identify skeletal and soft tissue abnormalities of the facial bones, sinuses and base of skull.

*Neck* — Studies to identify extent of soft tissue neoplasms of the pharynx.

*Chest* — Pleura — Studies to identify extent of pleural disease.

*Lung* — Studies for metastatic neoplasia.

*Heart* — No benefits will be provided.

*Thoracic Great Vessels* — Studies of the Thoracic Great Vessels will be reviewed individually, (IC); conventional angiographic methods provide more accurate information.

*Mediastinum* — Studies of the mediastinum for defining the nature of superior and anterior mediastinal and para-mediastinal lesions.

*Spine* — Studies for spinal stenosis.

*Spinal Cord* — Studies of the spinal cord will be reviewed individually, (IC).

*Retroperitoneum* — Studies for mass lesions.

*Pancreas* — Studies for mass lesions (neoplasms or inflammation including pseudocysts).

*Abdomen and Pelvis* — Studies for mass lesions.

*Biopsy* — Studies for localization and thin needle biopsy for staging malignant disease or diagnosis and possible drainage of abscesses.

*Treatment planning* — Studies to delineate a mass for radiation treatment.

*Kidney* — Studies of the kidney will be reviewed individually, (IC); ultrasound, nuclear medicine scans and conventional radiography can usually answer questions without CT.

*Biliary System* — Studies for obstructive conditions.

*Gallbladder* — Studies of gallbladder will be reviewed individually, (IC); conventional radiography and B-mode ultrasound provide more accurate information.

*Abdominal aorta* — Studies of abdominal aorta will be reviewed individually, (IC); properly performed B-mode ultrasound examination is considered highly efficacious.

*Pelvis* — Studies for staging tumors and delineation of masses, i.e. abscess, cysts.

*Extremities* — Studies to delineate primary bone tumors.

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With the report of a great discovery for a Conquest, some two or three Savage men, were brought in, together with this Savage custome. But the pitie is, the poore wilde barbarous men died, but that vile barbarous custome is yet alive, yea in fresh vigor: so as it seemes a miracle to me, how a custome springing from so vile a ground, and brought in by a father so generally hated, should be welcomed upon so slender a warrant. For if they that first put it in practise heere, had remembered for what respect it was used by them from whence it came, I am sure they would have bene loath, to have taken so farre the imputation of that disease upon them as they did, by using the cure thereof. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Bulletin Board

## NEW MEMBERS of the State Society

Adickes, George Cartwright, MD, (IM) 1100 Blythe Blvd., Charlotte 28203  
 Farham, Berlin Francis, Jr., MD, (CDS) 1900 Randolph Rd., Charlotte 28207  
 Havis, Herman (STUDENT) 212-D Branson Street, Chapel Hill 27514  
 Lark, Kenneth James, Jr., MD, (GE) 131 McDowell Street, Asheville 28801  
 Marmol, Hortensia Rita, MD, (INTERN-RESIDENT) 1402 Wyldewood Road, A-2, Durham 27704  
 Mennis, Kenneth Michael, MD (PD) 3-A Smathers Street, Clyde 28721  
 Muenchle, Robert Henry, MD, (P) 2901-G Cottage Place, Greensboro 27405  
 New, Philip Trafton, MD, (FP) 1009 Markham Avenue, Durham 27701  
 Off, David Albert, (STUDENT) L-8 Berkshire Manor, Carrboro 27510  
 Parlan, David Marshall, (STUDENT) 1911 Erwin Road, Apt. D., Durham 27705  
 Rayer, Robert Allan, MD, (IM) 2711 Randolph Rd., Ste. 100, Charlotte 28207  
 Rahn, Leonard Bernard, MD, (PTH) UNC, Dept. of Path. 228-H, Chapel Hill 27514  
 Razar, Ernest C., MD, 116 W. Market Street, Hertford 27944  
 Rhee, Jesse Thomas, III (STUDENT) Box 2811, Duke Med. Ctr., Durham 27710  
 Rhee, Joseph D., MD, (R) P.O. Drawer 575, Lincolnton 28092  
 Rhee, Cheryl Levine, MD, (PTH) 1740 Montclair Ave., Gastonia 28052  
 Rhee, Philip, MD, (PTH) 1740 Montclair Ave., Gastonia 28052  
 Rindow, Larry Gene, MD, 1949 Clematis Drive, Charlotte 28211  
 Riquade, John Francis, III, MD, (IM) 4511 Gloucester Dr., New Bern 28560  
 Rorris, Donald S., MD, Forsyth Mem. Hosp., Winston-Salem 27103  
 Rriver, David Clark, MD, (IM) 4607 W. Fairway Drive, New Bern 28560  
 Rrterson, Furnifold McLendel Simmons, Jr., M.D. (CD) Rt. 6, Box 78, Chapel Hill 27514  
 Rrters, Peter Demjantschuk, MD, P.O. Box 85, Broughton Hospital, Morganton 28655  
 Rrterson, David Marshall, Jr., MD, (IM) 3535 Randolph Road, Charlotte 28211  
 Rrther, Donna Lynn, MD, (INTERN-RESIDENT) 1540 Garden Terrace, Apt. 308, Charlotte 28203  
 Rrsen, Richard James, MD, (IM) 1032 Professional Village, Greensboro 27401  
 Rrunker, Kasturi G., MD, (U) 117 W. 7th St., Roanoke Rapids 27870  
 Rravender, Eugene Frank, MD, (OBG) 1821 Green St., Durham 27705  
 Rrlent, Eric Allen (STUDENT) Old Well Apts. 11-0, Carrboro 27510  
 Rrderhill, Thurlow Reed, MD, (U) 800 Hospital Dr. Ste. 4, New Bern 28560  
 Rrtan, Bruno Joseph, MD, (AN) Box 3094, Duke Med. Center, Durham 27710  
 Rriler, Stephen James, MD, (P) Box 3263, Duke Med. Center, Durham 27710  
 Rrilliams, Randal James, MD, (OPH) P.O. Box 2588, Hickory 28601

Woodward, Kent Thomas, MD, (TR) Duke Med. Ctr. Div. of Therapeutic Radiology, Durham 27710  
 Woodworth, Alfred Norman, MD, 118 Oakmont Drive, Greenville 27834  
 Worland, David Eric, MD, (AN) 208 Homewood Avenue, Greensboro 27401

## WHAT? WHEN? WHERE? In Continuing Education

Please note: 1. The Continuing Medical Education Programs at Bowman Gray, Duke, East Carolina and UNC Schools of Medicine, Dorothea Dix, Wayne County Hospital and Burroughs Wellcome Company are accredited by the American Medical Association. Therefore CME programs sponsored or co-sponsored by these schools automatically qualify for AMA Category 1 credit toward the AMA's Physician Recognition Award, and for North Carolina Medical Society Category A credit. Where AAFP credit has been requested or obtained, this also is indicated.

2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information."

### PROGRAMS IN NORTH CAROLINA

#### December 1-2

American College of Physicians — North Carolina Society of Internal Medicine Annual Meeting  
 Place: Sheraton Inn, Charlotte  
 For Information: Norman H. Garrett, M.D., 1038 Professional Village, Greensboro 27401

#### December 2

Pregnancy, Birth and Infancy: Origins of Attachment  
 Fee: \$35  
 Credit: 6 hours  
 For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### December 11-15

Industrial Toxicology  
 For Information: Mario Battigelli, M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

#### December 13

Office Gynecology  
 Place: Pitt County Memorial Hospital, Greenville  
 Fee: \$15  
 Credit: 3 hours; AMA Category 1  
 For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January-February

1st District Medical Society Postgraduate Course  
 Place: Edenton, Ahoskie  
 For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### January 10

Immunological Aspects of Malignancy  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category I  
For Information: F. M. Simmons Patterson, Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January 17

Wingate Johnson Memorial Lecture  
Fee: None  
Credit: 2 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### January 17

Office Recognition and Management of Sexual Dysfunction  
Place: Flame Steak House, Sanford  
Sponsors: Lee County Medical Society and Wake AHEC  
Fee: \$6  
Credit: 3.5 hours  
For Information: R. S. Cline, M.D., Director of Continuing Medical Education, Lee County Hospital, Sanford 27330

#### January 26-27

Urology Postgraduate Course  
Fee: \$100  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### February 1-3

Womack Surgical Society Meeting  
Place: Berryhill Hall  
For Information: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill 27514

#### February 2-3

North Carolina Conference for Medical Leadership  
Place: Sheraton Crabtree Motor Inn, Raleigh  
Sponsor: North Carolina Medical Society  
For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

#### February 14

Psychopharmacology Update  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category I  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### February 16-20

Basic Electroencephalography  
Credit: 30 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### February 19-23

Microvascular Surgery Workshop  
Credit: 40 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### March 3-4

Anesthesiology  
For Information: David Brown, M.D., Department of Anesthesiology, UNC School of Medicine, Chapel Hill 27514

#### March 8-10

Internal Medicine — 1979  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 9-10

2nd Outcome Workshop  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 9-10

Frank R. Lock Symposium in Obstetrics and Gynecology  
Fee: \$125  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### March 14

Recent Advances in Surgical Care  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category I  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### March 29-30

Annual Cancer Research Symposium  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 31-April 1

4th Annual Radiology Update  
Fee: \$50  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### April 2-6

7th Annual Tutorial — Radiology of the Chest  
Sponsor: The Department of Radiology, Duke University School of Medicine  
Credit: 30 hours

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For Information: Robert McLelland, M.D., Radiology-Box 3808,  
Duke University School of Medicine, Durham 27710

#### April 2-6

Chest Radiology  
Place: Ramada Inn, Durham  
Fee: \$300  
Credit: 30 hours  
For Information: Robert McLelland, M.D., Radiology Box 3808,  
Duke University Medical Center, Durham 27710

#### April 6-7

Practical Pediatrics  
Fee: \$35  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### April 11

Current Clinical Problems in Family Practice  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### April 12

Greensboro Academy of Medicine Annual Medical Symposium —  
Rheumatic Diseases  
Place: Jefferson-Standard Club, Greensboro  
Credit: 6 hours  
For Information: William Harrison Turner, M.D., 1030 Professional Village, Greensboro 27401

#### April 18-20

Mauney Orthopedic Lectures  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 20-22

Spring Radiology Seminar  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building, 202-H, School of Medicine, Chapel Hill 27514

#### April 27-28

21st Malignant Disease Symposium  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 27-28

Perspectives on Pain Management  
Fee: \$100  
Credit: 12 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### May 2-3

Annual Meeting of the North Carolina Thoracic Society  
Place: Royal Villa, Raleigh  
For Information: Mr. C. Scott Venable, Executive Director, North Carolina Lung Association, P.O. Box 127, Raleigh 27602

#### May 9-10

Respiratory Care Symposium: Breath of Spring 1979  
Fee: \$35  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### May 18-19

14th Annual Course in Perinatology  
For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

### ITEMS OF SPECIAL INTEREST

#### December 7-10

Thirty-Second American Medical Association Winter Scientific Meeting  
Place: Las Vegas  
For Information: Department of Meeting Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

#### February 12-16

Current Concepts in Diagnostic Radiology  
Place: Acapulco Princess Hotel, Mexico  
Sponsor: Department of Radiology, Duke University Medical Center  
Fee: \$250  
For Information: Robert McLelland, M.D., Radiology Box 3808, Duke University Medical Center, Durham 27710

#### March 5-8

18th National Conference of the Detection and Treatment of Breast Cancer  
Place: Atlanta, Georgia  
Sponsor: American College of Radiology  
For Information: American College of Radiology, 6900 Wisconsin Avenue, Chevy Chase, Maryland 20015

#### May 6-10

2nd International Symposium on Adolescent Medicine  
Place: Mayflower Hotel, Washington, D.C.  
Sponsor: The Society for Adolescent Medicine  
Fee: \$150  
For Information: The Institute for Continuing Education, P.O. Box 11083, Richmond Virginia 23230

#### Abdominal Real Time Sonography Courses

A series of six week-long courses on the use of Real Time Ultrasound in abdominal studies will be offered at Bowman Gray School of Medicine on the following dates: December 4-8, 1978; March 12-16, June 11-15, July 16-20 and December 9-13, 1979. Participants will receive 30 hours of Category 1 credit per week. For further information, please contact, James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem 27103

The items listed in the above column are for the six months immediately following the month of publication. Requests for listing should be received by "WHAT? WHEN? WHERE?", P.O. Box 27167, Raleigh 27611, by the 10th of the month prior to the month in which they are to appear. A "Request for Listing" form is available on request.

#### News Notes from the—

### DUKE UNIVERSITY MEDICAL CENTER

Fruit flies, swatted by housewives and ignored in recent years by researchers, have found a new champion in Dr. Arno Greenleaf.

The Comprehensive Cancer Center biochemist will use the tiny flies to help explain why normal cells develop normally, while cancer cells do not.

The American Cancer Society has awarded Greenleaf a \$130,000 grant for his work. He is an assistant professor of biochemistry.

Greenleaf said he will focus on genes in the innermost core of fruit fly (*Drosophila*) cells because they contain only about 5,000 genes. Human cells contain about 500 times that number.

\* \* \*

The director of education and evaluation of the Family Medicine Program has received a project grant

from the Department of Health, Education and Welfare to enhance the teaching, research and administrative skills of family medicine faculty members.

Dr. James A. Bobula, an assistant professor of community and family medicine, said the project was approved for five years, with a first-year budget of \$12,288 and a total support amounting to \$681,739.

Trainees will participate in one or more of four programs to be offered by the Division of Family Medicine. These include a one-year fellowship, a series of one-week workshops over a 10-month period, a single four-day workshop and on-site consultation by Duke family medicine faculty members at the trainee's institution.

\* \* \*

The keynote address at the founding meeting of the American Holistic Medical Society in Denver, was given by Dr. Eugene A. Stead Jr., professor of medicine. Stead spoke on "Growing Holistic Doctors."

The new society will sponsor educational and scientific programs for physicians and other health professionals. It will begin a journal and has established a newsletter which states that "Holistic medicine encompasses all safe modalities of diagnosis and treatment . . . emphasizing the necessity of looking at the whole person, including analysis of physical, nutritional, environmental, emotional, spiritual and life style values."

\* \* \*

Dr. Shirley K. Osterhout, assistant professor of pediatrics and clinical director of the Poison Control

Center, has been appointed as a consumer representative to the Technical Advisory Committee on Product Safety Packaging at the Consumer Product Safety Committee.

\* \* \*

The Burroughs Wellcome Fund has selected a noted British microbiologist as one of its six William N. Creasy Visiting Professor of Clinical Pharmacology for the 1978-79 academic year.

Professor Francis W. O'Grady of the University of Nottingham will spend a week here in April next year giving lectures and tutorials in the departments of pharmacology and medicine.

O'Grady is an expert on the use of antibiotics in treating bacterial infections.

\* \* \*

Dr. Gerald S. Lazarus, chief of the division of dermatology, has been named J. Lamar Callaway Professor of Dermatology.

Lazarus, 39, is the first physician to occupy the chair which was established last year to honor Callaway, chief of dermatology from 1946-75 and a member of the Duke faculty since 1937.

Callaway, who is James B. Duke Professor of Dermatology, is continuing his practice and research here.

A native of New York City, Lazarus earned a B.S. in chemistry at Colby College in 1959 and his M.D. at George Washington University School of Medicine in 1963.

Before joining the Duke faculty in 1975, he was associate professor of medicine at Albert Einstein College of Medicine in New York and head of dermatology at Montefiore Hospital.

\* \* \*

The Duke University Comprehensive Cancer Center has finished first among the nation's 19 comprehensive cancer centers in a review by the National Cancer Advisory Board.

The results of the review were published in the July 14, 1978, edition of The Cancer Letter.

The review scored the centers on 10 characteristics that the advisory board used to determine if a center were comprehensive.

Duke led all the centers in only one category, that of developing community programs for physicians in the area served. However, its strong ratings in all categories led to the overall ranking.

\* \* \*

One of the one-in-five Duke Hospital patients from outside North Carolina recently came from halfway around the world.

And because of the special nature of the treatment he was to receive, his physician came with him to observe the procedure firsthand.

Klaus Morlein, from Munich, West Germany underwent surgery for Wolff-Parkinson-White

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WPW) syndrome, a relatively rare congenital heart defect. A surgical technique for correcting the syndrome was developed at Duke by Dr. Will C. Sealy, professor of thoracic surgery, who performed Morlein's surgery.

Treatment includes "mapping" the heart to pinpoint for the surgeon the section of the heart muscle that requires surgery. This is done in the Clinical Electrophysiology Lab by Dr. John J. Gallagher and his associates. Gallagher, an associate professor of medicine in the division of cardiology, is director of the lab.

Sealy and Gallagher have become internationally known for their work with WPW during the past decade.

Morlein's physician, Dr. Hans Meisner, decided that his patient should come to Duke after consultation in Europe with Gallagher.

#### News Notes from the—

### EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

Dr. Charles Rob, an internationally known surgeon who pioneered techniques in vascular surgery, has joined the Department of Surgery at East Carolina University. A native of England, Rob will teach general and vascular surgery at the medical school and will be responsible for the development of a vascular laboratory which will provide consultation and referral services to area physicians.

Rob comes to ECU from the University of Rochester School of Medicine and Dentistry where he was professor and chairman of the Department of Surgery for 17 years. He served as consulting surgeon to the Penessee, Highland, Rochester General and St. Mary's Hospitals in Rochester. He is an honorary fellow of the Venezuelan Surgical Society, the Association of Surgeons of India, the Association of Surgeons of Great Britain and Ireland, and the Academy of Medicine, Toronto. He has been guest surgeon at hospitals and medical schools in England, New Zealand, Canada and Australia.

In 1975 the International Surgical Society awarded Rob the Rene Leriche Prize for the most valuable work on the surgery of arteries, veins or the heart which had appeared in recent years.

Rob received his M.D. from Cambridge University and completed his postgraduate training at St. Thomas's Hospital, London. He served as professor of surgery at the University of London before coming to the United States in 1960 to accept an appointment as chairman of surgery at the University of Rochester.

\* \* \*

Dr. Jarlath MacKenna has been appointed assistant professor in the Department of Obstetrics and

Gynecology. He will teach the management of high-risk pregnancies and will be responsible for the development of a consultation and referral service for high-risk obstetrics.

The author of numerous articles on maternal and fetal medicine, MacKenna has developed and evaluated placental function tests and recently participated in a national study evaluating the reliability of electronic testing of the fetus.

Prior to joining ECU, he was assistant professor of pediatrics and obstetrics and gynecology at the Eastern Virginia Medical School. He also served as co-director of the school's division of perinatal medicine.

A native of Ireland, MacKenna received his undergraduate and M.D. degrees from University College, Dublin. He did his internship and residency at Norfolk General Hospital and completed a fellowship in maternal and fetal medicine at Duke University Medical Center, where he also held a faculty appointment.

\* \* \*

Dr. Lane E. Jennings has been appointed instructor in the Department of Family Practice. He will be director of the department's undergraduate medical education program and serve as a faculty physician at the Eastern Carolina Family Practice Center, the primary care facility operated by the School of Medicine.

A native of Florida, Jennings received his undergraduate degree from Florida Atlantic University and his M.D. from the University of Miami School of Medicine. He recently completed his residency training at the Duke-Watts Family Medicine Program.

\* \* \*

Dr. Donald D. Weir, medical director for the Regional Rehabilitation Center in Greenville, has been named chairman of the medical school's Department of Rehabilitation Medicine, one of six new divisions recently established.

The other new departments include anesthesiology, community medicine, human genetics, radiation therapy and radiology and nuclear medicine. Chairmen for these departments have not been appointed.

Weir will coordinate clinical rotations for medical students at the regional center, a 55-bed facility adjacent to Pitt County Memorial Hospital. Prior to joining the center in June, he was director of rehabilitation at St. Luke's Hospital, Cedar Rapids, Iowa. He has held faculty appointments at the State University of Iowa and the University of North Carolina School of Medicine, where from 1958-1969 he was director of rehabilitation.

Weir received his undergraduate degree from Drake University and his M.D. from the State University of Iowa. He completed his postgraduate training at Johns Hopkins and Baltimore City hospitals.

\* \* \*

Three faculty members in the Department of Pharmacology presented papers at the annual meeting of the Society of Toxicology and the American Society for Pharmacology and Experimental Therapeutics.

Dr. John DaVanzo chaired a session on "Behavioral Pharmacology and Toxicology" and presented "Aggressive Behavior in Grouped Bulbectomized Mice." Dr. Andrea Hunter presented "The Effects of Pregnancy on the Biliary Excretion of Oubain" at the drug disposition session. Dr. Donald W. Barnes presented "Inhibition of Mixed Function Oxidase (MFO) Activity by Maleic Anhydride-Divinyl Ether Copolymers" at the biochemical pharmacology session.

\* \* \*

The ECU School of Medicine began its second academic year this fall with 36 students, all of them residents of North Carolina.

The students are 21 to 30 years old. All have expressed an interest in primary care and all are interested in practicing in the state after graduation.

Twenty-eight students are beginning their second year of study at the medical school.

\* \* \*

The School of Medicine and Pitt County Memorial Hospital experienced another "first" this summer when 24 additional residents joined the hospital's house staff. Physicians participating in the medical school's postgraduate training program now total 31. Last year seven residents were in training at the school's family practice center.

#### News Notes from the—

### BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

The Bowman Gray School of Medicine began its 37th year as a four-year school with the Aug. 28 enrollment of 108 students in the first-year class.

The Medical School has a total enrollment of 410 students this fall.

Classes for new students began Aug. 30.

The entering class was chosen from 4,722 applicants. The first-year students represent 18 states and Puerto Rico and a total of 49 colleges and universities. Sixty-seven of the students — 62% of the class — are from North Carolina. Applications from 440 North Carolinians were received for entry into the new class. Sixty North Carolina counties are represented in the class.

The class includes 18 women and 16 minority students, an increase of five minority students over 1977.

On the medical college admission test, the new students ranked above the national median score, which was eight out of a possible score of 15 on each of the test's six categories. The grade point average for the new class was 3.45.

Twenty-two new graduate students were enrolled this fall in the biomedical graduate studies program. A

#### BRIEF SUMMARY OF PRESCRIBING INFORMATION

#### ANTIMINTH® (pyrantel pamoate)

#### ORAL SUSPENSION

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

**Precautions:** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

**How Supplied.** Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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**When you're good  
people recognize you.**

Highly effective  
Single-dose convenience  
Non-staining  
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Pleasant tasting

**Antiminth<sup>®</sup>**  
**(pyrantel pamoate)**

equivalent to 50 mg pyrantel/ml  
ORAL SUSPENSION



a drug of choice in  
pinworm infections

Please see brief summary of prescribing information on facing page.

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**When painful spasm  
is the presenting  
symptom...**





... in functional G.I. disorders\*

# Bentyl<sup>®</sup>

## (dicyclomine hydrochloride USP)

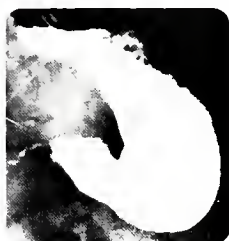
10 mg. capsules, 20 mg. tablets,  
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity  
with minimal anticholinergic side effects†

### Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

... Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

*"The correlation of spasm relief and drug given was excellent."*

\*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

#### Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med 5:356-358, 1964

# Merrell

# Bentyl® (dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection  
AVAILABLE ONLY ON PRESCRIPTION.

## Brief Summary INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGIC/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders), and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

**CONTRAINDICATIONS:** Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with autonomic neuropathy, hepatic or renal disease, ulcerative colitis—large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia; nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

**Usual Dosage:** Bentyl 10 mg capsule and syrup: Adults, 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg: Adults, 1 tablet three or four times daily. Bentyl Injection: Adults, 2 ml (20 mg) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

total of 82 students are studying in the graduate program.

\* \* \*

L. Stephen Nunn of Phoenix, Ariz., has been presented the James F. Wilson Memorial Award as the outstanding graduating student of Bowman Gray's Physician Assistant Program.

Nunn was one of 41 students who was graduated from the two-year program Aug. 24. Nunn served as president of the Katherine H. Anderson Society during his first year in the program and is a past president of the National Academy of Physician Assistants.

Six teaching excellence awards were presented by students to the faculty, staff and area physicians during the graduation ceremonies. Recipients were Dr. Calvin Busch, a cardiologist at Oteen VA Hospital; Dr. Scott Chatham, resident in obstetrics and gynecology at Forsyth Memorial Hospital; Dr. William F. Folds, a family physician in Winston-Salem; Gale Harkness, clinical coordinator of the P.A. program; Dr. Ronald B. Mack, associate professor of pediatrics; and Dr. Alfred J. Ruffy Jr., associate professor of medicine.

\* \* \*

The Nurse Anesthesia Program of Bowman Gray and North Carolina Baptist Hospital graduated twelve students during ceremonies Aug. 19.

The students, representing four states, received certificates signifying successful completion of the two-year program.

\* \* \*

Dr. Carolyn Huntley, professor of pediatrics at Bowman Gray, has received a \$178,074 grant from The John A. Hartford Foundation to further her research on what promises to be an improved method of testing for infections caused by the dog roundworm, *Toxocara Canis*.

The two-year grant permits Dr. Huntley to examine the possible use of an antigen produced by the roundworm common in pigs in a test for the *Toxocara Canis* infection.

The dog roundworm antigen is difficult to get in needed quantities and obtaining the antigen poses the hazard of infecting laboratory technicians.

Dr. Huntley is in the process of purifying the pig roundworm antigen, which is available in large quantities and is safer to obtain. Development of procedures for using the antigen in tests with serum taken from people suspected of having the infection will follow. Those procedures must then be tested before they can routinely be used with human serum.

\* \* \*

The North Carolina Chapter of the Society for Neuroscience has elected Dr. James G. McCormick as its president-elect.

McCormick is a research associate professor of otolaryngology at Bowman Gray. He will serve as the

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chapter's president during the 1979-80 academic year.

The chapter is one of the largest belonging to the national society. About 30 Bowman Gray faculty members belong to the chapter.

\* \* \*

Dr. F. A. Blount, assistant professor of pediatrics and associate medical director of Bowman Gray's Physician Assistant Program, has been appointed to the Clinical Rotations/Curriculum and Evaluation Committee of the National Association of Physician Assistant Programs.

\* \* \*

Dr. Vardaman M. Buckalew, professor of medicine, has been appointed a member of the Research Review Subcommittee of the North Carolina Heart Association for a three-year term.

\* \* \*

Dr. Thomas B. Clarkson, professor and chairman of the Department of Comparative Medicine, received the 1978 Charles River Prize from the American Veterinary Medical Association for his contributions to the field of laboratory animal science.

\* \* \*

Dr. Donald L. Copeland, associate professor of family medicine, has been appointed to the Medical

and Community Program Committee of the North Carolina Heart Association.

\* \* \*

Dr. Joseph E. Johnson III, professor and chairman of the Department of Medicine, has been elected secretary-treasurer of the Association of Professors of Medicine.

\* \* \*

Virginia MacFarlane, instructor in allied health, has been appointed to the Behavioral Sciences/Communication Skills Committee of the National Association of Physician Assistant Programs.

\* \* \*

Sandra Maree, assistant director of Bowman Gray's Nurse Anesthesia Program, has been appointed to the ad hoc Council of Re-Certification of the American Association of Nurse Anesthetists.

\* \* \*

Dr. Jesse H. Meredith, professor of surgery, represented the North Carolina Medical Society Aug. 22 at the meeting of the North Carolina Voluntary Cost Containment Committee in Raleigh.

\* \* \*

Dr. Richard C. Proctor, professor and chairman of

## TEGA-SPAN CAPELLETS

### TEGA-SPAN CAPELLETS FOR MORE ADVANCED NICOTINIC ACID THERAPY

Each capsule contains: . . . 400 mg of pure pelletized  
Nicotinic Acid

**INDICATIONS:** Tega-Span is indicated where reduction of serum chloolesterol and total lipid levels in hypercholesteremia and hyperlipemia is desirable. It may also be useful in reducing xanthomatous tissue cholesterol deposits.

**DOSAGE AND ADMINISTRATION:** Usual dose is one or two capellets twice daily with or after meals. Since lower doses may control hyperlipidemia in some patients, the dosage should be individualized according to the effect on serum lipid levels. It is also to be noted that adverse reactions appear with greater frequency early in therapy; in order to avoid these it may be best to start the drug at low levels and increase dosage gradually.

*Federal Law prohibits dispensing without a prescription*

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

**ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205**

the Department of Psychiatry, has been appointed to work with the North Carolina Industrial Commission by the North Carolina Medical Society.

\* \* \*

Michael D. Sprinkle, director of Bowman Gray's library, has been elected to the Advisory Board of Excerpta Medica.

#### News Notes from the

### UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

Dr. Eng-Shang Huang, assistant professor of medicine and a member of the Cancer Research Center, has received a \$383,535 grant from the National Institute of Allergy and Infectious Diseases for his research with cytomegalovirus (CMV). When passed on by a pregnant woman to her unborn child, the microorganism can cause mental retardation, prematurity, congenital defects and fetal death.

CMV is one of many viruses suspected of somehow combining with environmental factors and human-host vulnerability to ultimately cause cancer. Huang and his associates have isolated CMV genetic material in human tumors, a first step in proving a cancer link for any infectious agent.

Huang's laboratory in Chapel Hill has become one of the leading centers for basic study of this virus. Scientists throughout the world send him tissue samples from patients suspected of suffering from CMV-caused diseases.

\* \* \*

Charles T. Martin has been named associate director of the Medical Faculty Practice Plan of the medical school. The plan manages financial affairs and patient billing for the medical school faculty.

Martin has served for the past two years as assistant director of the Medical Service Plan office at the University of Michigan.

\* \* \*

Dr. Marion Phillips has been named associate dean of the medical school. He has been an assistant dean of student affairs since 1973. His expanded duties include grievance and appeals mediation and arbitration for N.C. Memorial Hospital and the university, membership on numerous medical school committees, and medical school recruitment and counseling.

\* \* \*

Dr. Arthur H. Lockwood, an assistant professor of anatomy and a member of the Cancer Research Cen-

**Tenuate®**  
(diethylpropion hydrochloride NF)

**Tenuate Dospan®**  
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

#### Brief Summary

**INDICATION:** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS:** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS:** **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSE AND ADMINISTRATION:** Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSSAGE:** Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.  
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

MERRELL-NATIONAL LABORATORIES  
Division of Richardson-Merrell Inc.  
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

**Merrell**

B-3921 (Y587A)



**Whether overweight is a  
complicating factor...  
or just uncomplicated overweight.**

# **Tenuate Dospan<sup>®</sup> <sup>IV</sup>**

**(diethylpropion hydrochloride NF)**  
**75 mg. controlled-release tablets**

## **A useful short-term adjunct in an indicated weight loss program.**

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

## **In uncomplicated obesity.**

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

## **Clinical effectiveness.**

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.<sup>1</sup> And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."<sup>2</sup> Compared with the amphetamines, diethylpropion has minimal potential for abuse.

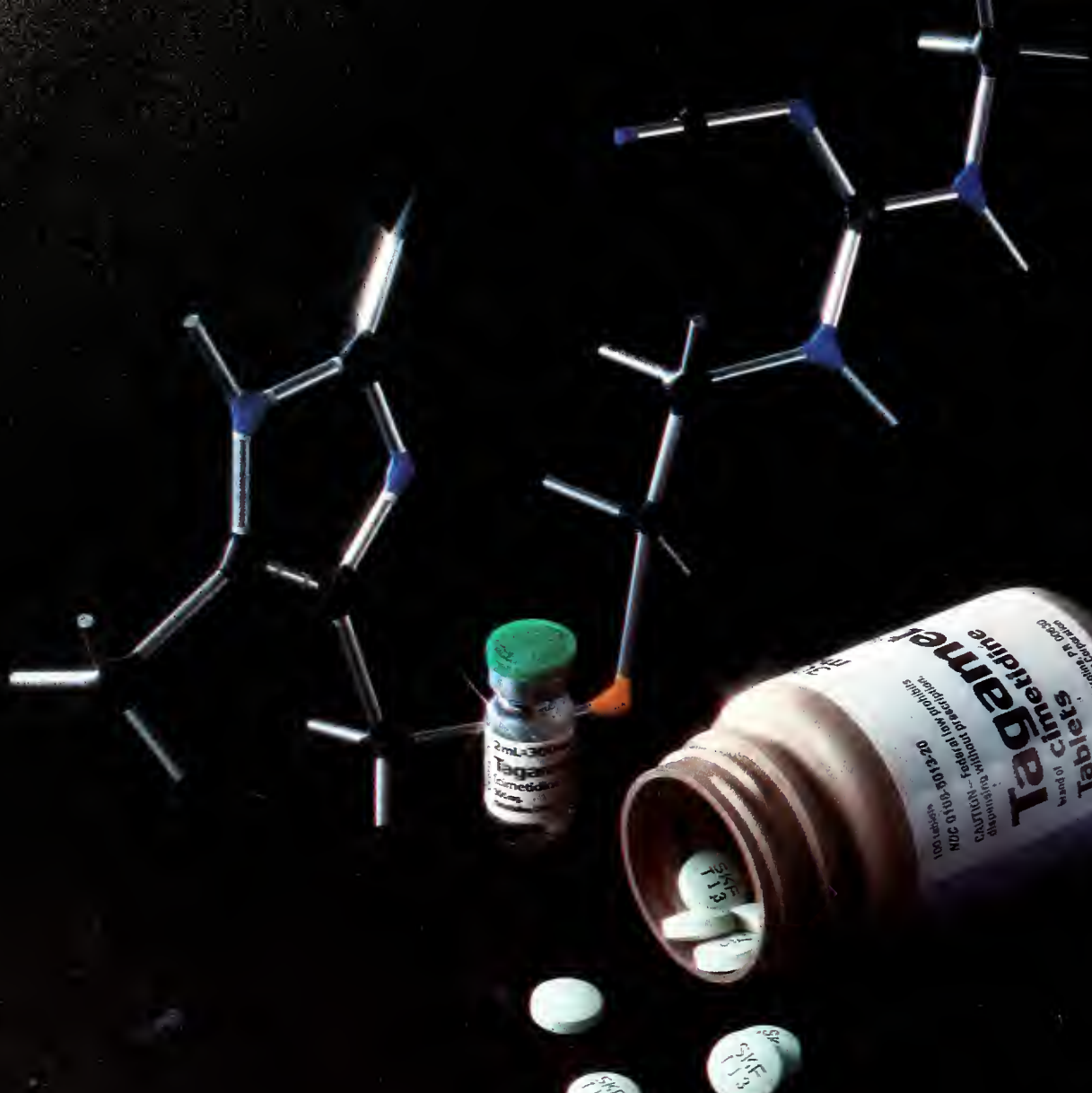
**Tenuate—it makes sense.  
And it's responsible medicine.**

# **Merrell**



For prescribing information see opposite page.





# Tagamet<sup>®</sup>

brand of

## cimetidine

**How Supplied:** Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).

Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

**SK&F LAB CO.**  
a SmithKline company



ter, has been awarded a \$201,000 four-year grant by the National Institute of General Medical Sciences to support his research into changes that occur in malignant cells.

He is also investigating the existence in mammals of compounds similar to cancer-fighting drugs and has received a \$10,000 grant from the Anna Fuller Fund to support this aspect of his research.

Lockwood was recently named a special fellow by the Leukemia Society of America and will receive \$31,000 during the next two years to support his leukemia-related research.

\* \* \*

The efforts of Dr. Joseph S. Pagano, director, and colleagues in the Cancer Research Center to evolve a "unifying hypothesis" linking benign infectious mononucleosis and Burkitt's lymphoma and nasopharyngeal cancer were reported in an article titled "Tracking the Epstein-Barr Virus" in *Science News*, June 3.

\* \* \*

Dr. Edward V. Staab, professor of radiology, has been named chairman of the Academic Council of the Society of Nuclear Medicine. The council is composed of all directors of nuclear medicine training programs in the United States. Staab presided over the national meeting of the council in Anaheim, Calif., in June. He has also been elected president of the

Southeastern Chapter of the Society of Nuclear Medicine.

\* \* \*

Dr. Stephen Haskill, ob-gyn, and Dr. Stephen W. Russell, associate professor of pathology, were among 16 international leaders in the field of cancer research invited to participate in the International Cancer Research Workshop, "In-Situ Expressions of Anti-Tumor Immunity," at Tel Aviv University. The symposium was the first scientific meeting devoted exclusively to in-situ tumor immunity.

\* \* \*

Jo Ann Flair, director of the patient education center at N.C. Memorial Hospital, presented a state-of-the-art review paper on patient education at the 1978 meeting of the Medical Library Association in Chicago.

\* \* \*

Dr. Margaret L. Moore, professor of physical therapy, presented the 13th Mary McMillan Lecture at the American Physical Therapy Association's 54th annual conference in Las Vegas. The lectureship is the highest honor awarded by the association.

\* \* \*

Dr. Christopher C. Fordham III, dean of the School of Medicine and vice-chancellor of UNC-CH for

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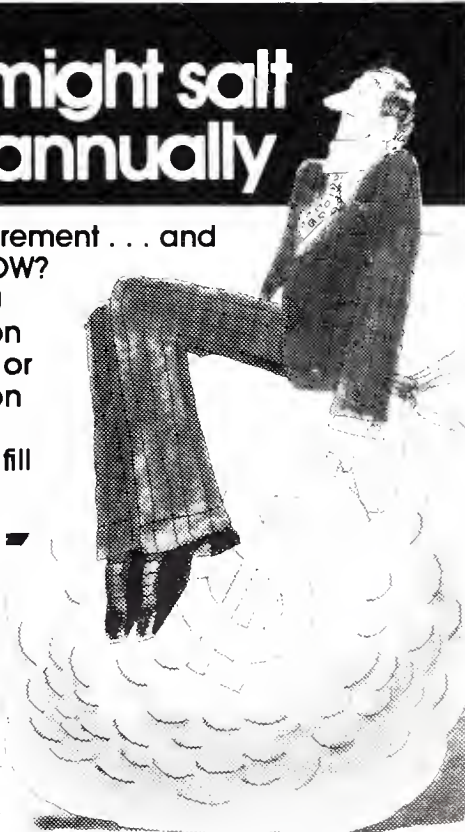


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health affairs, spoke to the American Pharmaceutical Association's annual meeting in Montreal on "Health Professional Manpower Issues: A Perspective."

\* \* \*

Dr. James H. Scatliff, chairman of radiology, presented "Computerized Tomography in the Assessment of Spinal Dysraphism" at the eleventh Neuro-radiological Symposium in Wiesbaden, Germany. He also evaluated x-ray equipment at several European manufacturing plants.

\* \* \*

A master's degree program in occupational therapy, the only such graduate degree in North Carolina, has been established in the department of medical allied health professions in the UNC-CH School of Medicine.

Ten students, the majority from North Carolina, will make up this fall's first class, says Dr. Marlys Mitchell, director of the program and associate professor in the medical school. Mitchell said the state is in desperate need of occupational therapists and she predicts that most members of the class will remain in North Carolina when they graduate.

\* \* \*

Dr. Pierre Morell, professor of biochemistry and nutrition, has been named director of the UNC-CH curriculum in neurobiology.

Morell, who joined the UNC-CH faculty in 1973, has taught at the Albert Einstein College of Medicine, where he earned his Ph.D. in 1968. He received his B.A. from Columbia College of Columbia University in 1963.

\* \* \*

Dr. Thomas R. Griggs, assistant professor of medi-

cine and pathology, has been named a Jefferson-Pilot Fellow in Academic Medicine.

Griggs will use his fellowship to study the diagnosis and treatment of coronary patients in an effort to learn and teach improved methods of coronary patient care.

The fellowship program, established in 1971 by the Jefferson-Pilot Corporation, is designed to attract and hold young faculty to the UNC-CH School of Medicine. The fellows are selected by a committee of medical faculty at UNC-CH.

Griggs received his M.D. degree from the UNC-CH School of Medicine.

\* \* \*

### Appointments

New faculty, effective July 1, are Robert A. Eisenberg and Jorge J. Gonzalez, assistant professors, department of medicine; and Fran S. Larsen, assistant professor, department of family medicine.

Eisenberg has been a research fellow in immunopathology and immunology at the Scripps Clinic and Research Foundation in California since 1975. He received his B.A. from Haverford College and his M.D. from Stanford University.

Gonzalez has been an instructor at the Medical University of South Carolina and an associate investigator at the Veterans Administration Hospital at Charleston, S.C., for the past two years. He earned his M.D. at the University of Chile.

Larsen comes to Chapel Hill from the University of California at Los Angeles, where he was an assistant professor of medicine. He also has been assistant director of medical education and director of the Family Care Center at General Hospital in Ventura, Calif. Larsen earned his B.S. and M.S. degrees at Michigan State University and his M.D. at the University of Washington.

---

... as I have already said, in regard that this *Tobacco*, is not simply of a hot and dry qualities; but rather hath a certaine venomous facultie joyned with the heate thereof, which makes it have an Antipathie against nature, as by the hatefull smell thereof doeth well appeare. For the nose being the proper Organ and convoy of the sense of smelling to the braines which are the onely fountaine of that sense, doeth ever serve us for an infallible witnesse, whether that Odour which we smell, be healthfull or hurtfull to the braine (except when it fals out that the sense it selfe is corrupted and abused through some infirmitie, and distemper in the braine.) — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Special From Washington

One of the thornier problems confronting health care planners, policymakers and providers — the geographic distribution of health manpower, particularly physicians — was the subject of a recently completed study by the General Accounting Office.

In a report to Congress the GAO said that \$430 million in federal funds had been spent during fiscal years 1972-77 in an effort to increase the supply of physicians in shortage areas.

According to the GAO, some 384,900 non-federal physicians — 369,800 M.D.s and 15,100 doctors of osteopathy — are unevenly distributed throughout the United States. Of the M.D.s, approximately 292,200 (79%) are providing patient care. But although this works out to 137 physicians for each 100,000 persons, a disproportionately large number are located in urban areas, where the physician-to-population ratio is significantly higher than in rural areas. Furthermore, the GAO reported, distribution is also "inequitable" within urban centers.

As for the 20,000 new physicians on whom data were available, they followed the path of their predecessors: 90% of the 1967-71 U.S. and foreign medical graduates licensed located in cities.

The study attributed the urban concentration of recent graduates primarily to the fact that most physicians, other than general and family practitioners, choose urban practice locations. The latter are more uniformly distributed between urban and rural areas, the GAO said.

"Preference for rural or urban living and the availability of clinical support facilities and personnel were equally important factors affecting the location decisions of a sample (1,066) of physicians licensed in 1971," the GAO found. "As a group, however, professional considerations, including clinical support, contact with other physicians, and continuing education opportunities, played the largest role. Overall, the physicians stated they had not been greatly influenced by economic factors, such as income potential and the availability of loans."

Reporting on the National Health Service Corps, the GAO told Congress:

"The Corps has undoubtedly increased the availability of physicians' services in communities designated by HEW as having a critical shortage of health manpower. However:

—"The Corps has not adequately considered the demand for medical services when assessing the need for physicians in shortage areas. This,

coupled with its decision to place a minimum of two physicians at most sites to the extent possible, has resulted in many physicians being underused in terms of patients served at sites in operation one year or longer.

—"The Corps has experienced difficulty in recruiting physicians willing to voluntarily practice in the more remote, less populated areas. Consequently, many of these sites have remained unstaffed for periods ranging up to four years.

—"Corps officials look to the HEW scholarship program with its shortage area service obligation to provide a sufficient supply of physicians in the future. But, because of deferments for graduate medical education, HEW officials do not expect a substantial number of physicians to be available until fiscal year 1979.

"It should be recognized, moreover, that the number of physicians authorized by the Corps for its unstaffed sites may exceed the number needed as evidenced by the low use of Corps physicians at many sites in operation one year or longer. This raises serious questions to GAO concerning the extent of unmet demand for health care in some of these areas and, therefore, the number of additional physicians with scholarship service obligations that will be needed to serve in HEW-designed shortage areas.

—"From inception through July 1976, only 42 physicians — out of a total of about 800 who served in the Corps — remained in the shortage areas or were planning to do so, as private practitioners, which is a major program objective."

As for loan repayment programs, the GAO found them relatively ineffective.

"As of October 31, 1977," the report said, "the federal loan repayment program attracted only 762 physicians (about 1.7 percent of those eligible) to shortage areas in return for loan repayment. Moreover, the majority of those who participated through February 1976 probably would have established practices in those shortage areas anyway. Thus, it seems the program provided financial benefits predominantly to physicians who already had decided on shortage area practice."

The GAO found it hard to assess the effectiveness of area health education centers.

"The long-term nature of the program, the lack of clearly defined national strategy, and different developmental stages and program strategies among the

11 area health education centers make identifying and assessing the program's impact difficult. Nevertheless, GAO believes this program conceptually has considerable long-term potential to indirectly improve health manpower distribution by overcoming some of the important professional objections to shortage area practice."

Both the preceptorship and family medicine training programs were too new at the time of GAO's review to determine their impact on increasing the supply of physicians in shortage areas.

In an effort to assess state and private efforts to improve access to primary care medical services in rural areas through programs relying heavily on non-physician providers (including nurses and physician extenders) the GAO visited four such programs:

The North Carolina Rural Health Centers; Kentucky Frontier Nursing Service; Checkerboard Area Health System; and East Kentucky Health Services Center. All use physician extenders as principal providers of health care in rural clinics. The physician extenders provide services under the supervision of physicians, but physicians are not always present when the services are performed.

The inability to receive reimbursement from Medicare (part B) and some other third-party payers for physician extender services at independent sites such as those discussed above had apparently restricted their potential widespread use.

"In 1965," the GAO reported, "when Medicare was enacted, there were few if any physician extenders working and no allowance was made for their reimbursement." But, the report continued, "on December 13, 1977, the President signed into law the 'Rural Health Clinic Services Act,' authorizing reimbursement under Medicare (part B) and Medicaid for services rendered in certain rural health clinics in underserved areas. Among the services covered are those of physician assistants and nurse practitioners, whether or not a physician is physically present at the time the service is provided.

"The act also requires the Secretary of HEW to conduct demonstration projects in urban medically underserved areas with respect to reimbursement on a cost basis for services provided by physician-directed clinics which employ physician assistants and nurse practitioners.

"In GAO's view, now that reimbursement for physician extender services rendered in rural clinics in underserved areas has been authorized, projects which rely extensively on physician extenders at satellite clinics or in mobile units with backup from physicians in larger neighboring communities could constitute an approach for providing health care to communities in the nation otherwise unable to attract or retain physicians."

The General Accounting Office recommended that the Secretary of Health, Education and Welfare should:

- Develop guidelines for assessing under what circumstances it would be appropriate to assign

health care providers to entities requesting Corps assistance and the number and type of provider(s) that would be most appropriate.

- Require communities and other entities requesting Corps health care providers to conduct studies which identify, to the extent possible, the number and types of residents located therein who are likely to seek care from a Corps-sponsored practice.
- Develop multi-year projections to assess the total number of physicians with scholarship commitments that will be needed to serve in shortage areas.
- Make an analysis of the extent to which family practitioners and other specialists are locating in HEW-designated shortage areas and based upon this analysis submit to the Congress recommendations for financially supporting those programs which constitute the greatest resource for providing health care to medically underserved areas.
- Work with the states to identify those areas having health manpower distribution problems and develop a strategy for marshaling resources — federal, state, and private — to establish an integrated program designed to provide health services in the manner most appropriate to each area.
- Examine those programs which rely on physician extenders to help deliver health services to those areas otherwise unable to attract physicians and consider seeking legislation which would provide federal funds to help develop those programs found to be most useful.

Addressing its recommendations to Congress, the GAO said it believes it is doubtful that a separate loan repayment program is still needed to attract physicians to shortage areas in view of the (1) expanded Corps scholarship program and number of physicians expected to be available for shortage area service; and (2) discretion available to the Secretary of HEW under the Health Professions Educational Assistance Act of 1976 to repay the newly authorized federally insured health professions student loans.

Therefore, the Congress should reconsider whether the loan repayment program for physicians needs to be continued since "it has not induced substantial numbers of physicians to enter shortage area practice and many physician participants apparently received windfall repayment of their education loans by the federal government since they would have established their practices in those shortage areas anyway."

The report continued:

The Congress should also reconsider the necessity for HEW to complete its study on physician extender reimbursement as required by the Social Security Amendments of 1972 in view of the "recent legislation enacted that provides for (1) Medicare (part B) and Medicaid reimbursement for physician extender (physician assistants and nurse practitioners) services rendered in certain rural health clinics in medically



underserved areas; and (2) demonstration projects to be conducted with respect to reimbursement for services provided by physician-directed clinics which employ physician assistants and nurse practitioners.”

HEW, which agreed with most of the GAO recommendations, said it was also concerned about the possible underuse of Corps physicians and that it must consider alternative health care delivery modes or staffing arrangements for those HEW-designated shortage areas which cannot sustain fulltime medical practices or retain physicians. HEW expects some progress toward improved use to occur as major bar-

riers to the use of physician extenders are reduced (i.e., eligibility for reimbursement and limitations of licensure).

HEW also stated that existing National Health Service Corps sites will not be continued if sufficient support for the corps project has not been demonstrated over the period of Corps involvement.

The GAO said it had considered comments made by officials of the programs and projects reviewed, and those of the American Medical Association, in preparing its report.



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60	27	3 teasp. (15 ml)	1½ tablets
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Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
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Below 15	Use not recommended

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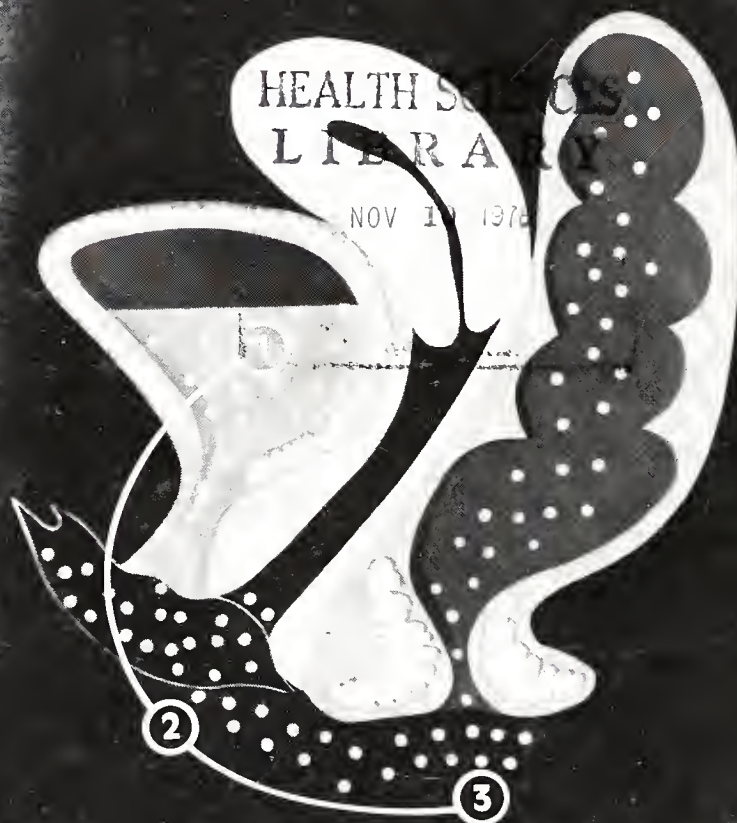
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# NORTH CAROLINA

## *Medical Journal*

The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY □ □ □ November 1978, Vol. 39, No. 11

### IN THIS ISSUE:

**CURRENT CONCEPTS: Cancer in Children:** J. Hugh Bryan, M.D., John M. Falletta, M.D., and Richard B. Patterson, M.D.

**California Virus Encephalitis in North Carolina:** Doris S. Kelsey, M.D., and Baldwin Smith, M.D.

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1979 Leadership Conference  
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1979 Annual Sessions  
May 3-6—Pinehurst

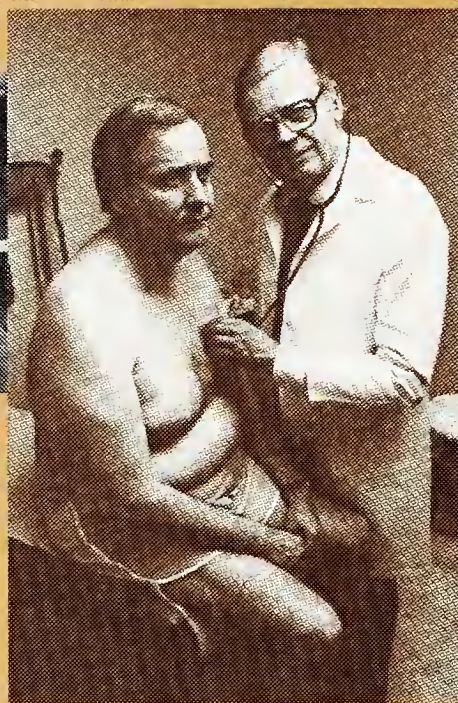
1979 Committee Conclave  
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***synonymous with relief of anxiety***

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**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral-Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions).

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For Your Information

## Continuing Medical Education Membership Requirement

North Carolina  
Medical Society

### REQUIREMENTS:

150 hours every three years —  
at least 75 hours in Category A

### CATEGORY A:

Courses or activities sponsored or approved by recognized medical education centers and agencies (university-based, AHEC, etc.), medical societies (local, North Carolina, and AMA), or medical specialty and scientific societies, AMA accredited audio-tapes.

### CATEGORY B:

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- A 25% discount off our published normal time and mileage rates (customer furnishes gasoline.)
- A 15% discount off System Presold Rates (customer furnishes gasoline.) These are special unlimited mileage rates such as See America and Florida Freedom Rates.
- A 10% discount off normal time and mileage rates and flat rates (where available) in Canada.
- A 10% discount off normal rates at International locations.

The discounts are offered on both business and personal rentals. To assure receiving the special discounts, North Carolina Medical Society members must always identify themselves at the Avis counter by presenting their North Carolina Medical Society membership card with the A.I.D. (Avis Incremental Discount) number A/A 6012 00 attached or visible in conjunction with (1) an Avis charge card or (2) presenting an Avis-honored charge card (American Express, Master-charge, Visa, etc.)

**The Avis Incremental Discount Card/Sticker identification was enclosed with the October "Bulletin." If you did not receive your A.I.D. card/sticker, it is suggested that all members immediately write the North Carolina Medical Society A.I.D. number A/A 6012 00 on the front of their North Carolina Medical Society membership card, or contact the Medical Society Headquarters Office, P.O. Box 27167, Raleigh, N.C. 27611.**

# NORTH CAROLINA MEDICAL JOURNAL

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November 1978, Vol. 39, No. 11

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Merit	8	0.6

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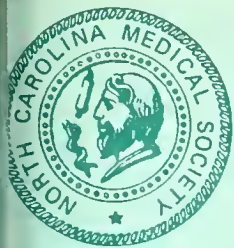
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# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

No. 6

NOVEMBER 1978

I am concerned that 635 physicians have yet to complete the Society's Continuing Medical Education requirement. One Hundred thirty-eight physicians have reported partial hours but 497 have reported no hours to the headquarters office. I would encourage each of you who have not completed this requirement to take a few minutes and compile your CME activities and forward them to the headquarters office before December 31, 1978.

On November 2, 1978, Governor James Hunt announced the appointment of Hugh H. Tilson, M.D., as Director of Health Services. He was born in New Kensington, Pa., graduated from Washington University School of Medicine, St. Louis, and obtained his Ph.D. and M.P.H. in Public Health from Harvard School of Public Health. He comes from the Department of Human Services, Multanomah County, Portland, Oregon, and will assume his duties January 1, 1979.

I would like to report to you additional items of interest from the Annual Committee Conclave and the Executive Council meeting held in September in Mid Pines.

The Committee on Communications suggests that each county medical society support and endorse efforts of the Medical Auxiliary to tape interviews with physician members for broadcast by radio and TV stations. They also endorsed and recommended position papers be prepared by the Society on various health issues.

The Committee on Eye Care recommended that all reasonable effort be made to see that a code for donation of eyes or other human tissue be made an integral part of the North Carolina Driver's License.

The Committee on Pharmacy recommended disapproval of blanket substitution authorization by physicians to pharmacists but encouraged pharmacist-physician consultations regarding choice of brands as a cost effective measure. The Committee opposed HEW's "Treatment Guide to Drug Prices".

The Committee on Disaster & Emergency Medical Care recommended that the portable heart and defibrillation device called "Heart Aide" not be approved at this time due to lack of sufficient scientific data.

The Committee on Health Planning recommended that a physician in each HSA District be appointed to attend, participate, and monitor the HSA Health Projects and Plans Committees.

The Committee Advisory to Crippled Children's Program, recognizing the need for continuation of the Crippled Children's Program, recommended that the Medical Society request Governor Hunt to appropriate 1.2 million dollars in emergency funds to maintain care in the Crippled Children's Program until the Legislature meets in January 1979. At that time a presentation will be made to the Legislature defining the management and coverage of the program. An additional request will be made for 1.9 million dollars for coverage of the program until June 30, 1979.

The Committee on Social Services Programs and the North Carolina Medical Society commends the work of Jake Koomen, M.D., on his retirement as Director of the Division of Health Services.

The Committee on Allied Health Professionals Chairman, Frank M. Mauney, M.D., Asheville, requests that any Society member who may have any complaints or questions concerning activities of the Physician's Assistants practicing in the State, please report these directly to him.

The North Carolina Medical Society Foundation, Inc., met on October 1, 1978. Members of the Foundation are the voting members of the Executive Council of the North Carolina Medical Society. President Jesse Caldwell, Jr., M.D., presided and Secretary-Treasurer, Jack Hughes, M.D., gave the financial report. Past Society President, E. Harvey Estes, Jr., M.D., was elected as the new President.

I hope each one of you is still seriously considering cost containment in your practice and hospital. Here are some interesting figures from a 265 general community hospital. Hospital charges only for treatment of 14 days for an acute myocardial infarction were \$2,156.10 and \$601.33 of that was for ancillary fees. Hospital charges for a cholecystectomy of a ten day stay was \$1,468.98 with \$801.59 of this for ancillary fees. The hospital charge for a pediatric gastroenteritis admission of four days was \$358.30 with \$118.26 for ancillary fees. It is interesting to note what percentage of the hospital bill is ancillary charge. I hope by now that physicians have a list of fees for his or her hospital charges for ancillary services. The ordering of unnecessary tests or x-rays certainly does increase a patient's hospital bill.

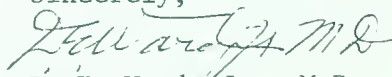
Joseph Peters, N.C. Department of Human Resources, has made a fee update for the Medicaid Physician. All Medicaid providers will be informed of these changes via the next Medicaid Bulletin. He suggests that all Medical Society members use CPT and ICDA coding on their Medicaid claims whenever possible. Seminars designed to explain Medicaid coding and billing procedures for office employees have been planned for the month of November. Three seminars for the eastern region are: November 16, Lumberton; November 29, Greenville; and November 30, Reidsville. When arrangements with EDS Federal are completed, additional seminars will be arranged in other areas. Each physician Medicaid provider should check with his secretary to see that she is coding Medicaid claim forms properly.

It is a pleasure to announce that Mr. Thomas L. Adams will join the Medical Society staff November 16, 1978, as Director, Governmental Affairs. He is a North Carolina native of Weaverville, N.C. who graduated from Lenoir Rhyne College and was previously Executive Assistant, U.S. Rep. Lamar Gudger, Washington, D.C. From August 1977 to present, he has been Special Asst. to former Governor Robert W. Scott, Federal Co-Chairman for Congressional Relations, Appalachian Regional Commission. He brings political experience to our legislative efforts for the coming year.

The impaired physician is still a problem in our society. The two leading problems confronting face in persuading physicians to enter treatment are denial of illness and concern over possible loss of income. The Committee on Physician's Health and Effectiveness, Theodore R. Clark, M.D., Chairman, Pinehurst, is working hard on establishing contacts and providing treatment for the impaired physician. Your Society would like to provide every assistance possible in treatment of the impaired physicians in our State.

Past President James E. Davis, M.D., Durham, has been elected Vice-Chairman, State Health Coordinating Committee. C. Douglas Maynard, M.D., Winston-Salem, has been named President, Society of Nuclear Medicine. Christopher C. Fordham, M.D., has been named to the National Academy of Scientist's Institute of Medicine.

Sincerely,

  
D. E. Ward, Jr., M.D.  
President



# "THE PHYSICIAN IS A DECISION MAKER, AND ALMOST EVERY DECISION HE MAKES COSTS OR SAVES MONEY."

—Dr. William Felts, Past President,  
American Society of Internal Medicine



More and more physicians today are beginning to realize the extent of the economic influence they have, and are finding ways of holding costs down.

A number of studies show that the more physicians *know* about costs, the more they try to *reduce* them.\* And this reduction can be done without reducing the quality of care to the patient.

How are they doing this? As a start they have become thoroughly familiar with the costs they incur on behalf of their patients. They know how much an X-ray costs, how much their hospital charges for routine lab tests. They're requesting copies of patients' hospital bills. And asking their hospitals to print the charges for diagnostic tests right on the order sheet.

What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

\*PATIENT CARE Magazine—Outlook 1977 "Face-Off: Cost Containment vs. Chaos," January 1, 1977

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



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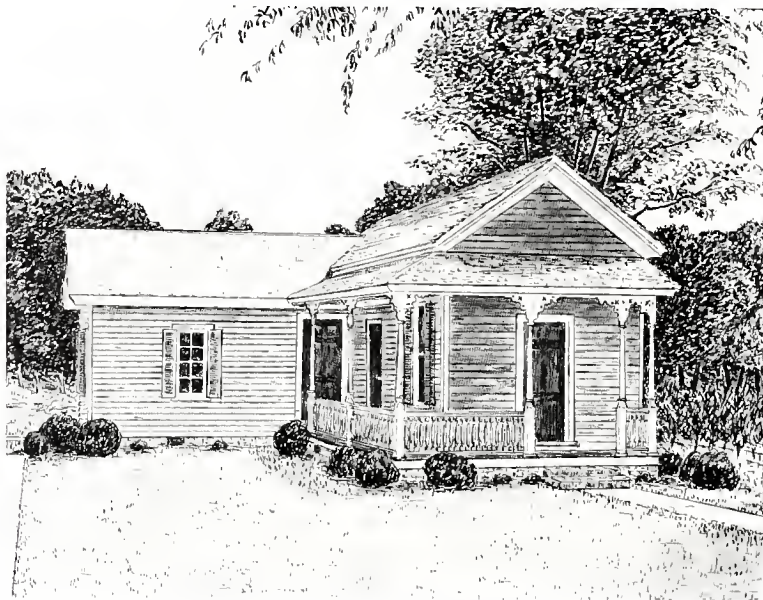
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# CURRENT CONCEPTS

## Cancer in Children

J. Hugh Bryan, M.D.<sup>\*</sup>, John M. Falletta, M.D.<sup>\*\*</sup>, and  
Richard B. Patterson, M.D.<sup>†</sup>

THE occurrence of cancer in children is an uncommon event. In order to determine precisely how common, a complete survey of children within a defined geographical area for a defined period of time would be required to identify the number of children in the population (population at risk) and the number of children who were found to have cancer as a new diagnosis during that time (affected population). No such survey has been performed in North Carolina. And since nearly half of all children with cancer survive their illness, estimates of cancer incidence derived from mortality statistics are inherently inaccurate.

Some population-based surveys have been performed. Using a study in which the population at risk resembled that of North Carolina children by racial distribution, we can estimate that nearly 200 North Carolina children under 15 years of

age would be identified as new cancer patients each year. The most common cancer in children is leukemia (Table I), with about 98% of these being acute leukemia and about 80% acute lymphatic leukemia. Approximately 65 North Carolina children would be expected to develop leukemia each year. Brain tumors will occur with one-half the frequency of leukemia and lymphomas are approximately one-third as likely to occur. Each of the remaining malignancies is less common, although the diseases represented include most of those that occur only in children.

In the following discussion we describe the clinical and therapeutic features of many of these malignancies to illustrate why the pediatric oncologist can be relatively optimistic about the future of the child with cancer.

### ACUTE LYMPHATIC LEUKEMIA

In the past 30 years of cancer chemotherapy some of the most impressive strides have occurred with children with acute lymphatic leukemia (ALL). From an average life expectancy after diagnosis of three to four months in 1948, we have come to expect a survival of five years in over half the children being treated, most of whom have

had no recurrence. Ten-year survivors are becoming more commonplace; many of these children may be cured. Since most of this improvement has been achieved without the introduction of significant new drugs since 1960, it must be attributed to other factors. Certainly improved supportive care with better antibiotics and transfusions of red cells, white cells and platelets have provided protection to the child until the disease is clinically controlled.

Today complete remission (no evidence of disease in the bone marrow or peripheral blood together with normal physical findings and activity) is obtained initially in more than 90% of the patients with ALL after treatment with vincristine and prednisone. This return to normal is usually maintained by using a combination of oral 6-mercaptopurine and methotrexate, usually with the addition of other drugs periodically over the next three years to accelerate leukemic cell destruction.

Perhaps the most significant advancement in achieving long-term survival has been the use of central nervous system (CNS) prophylaxis (treatment of occult disease) by intrathecal injections of methotrexate, cranial irradiation, or both. Because the blood/brain barrier is

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Reprint requests to Dr. Bryan

**TABLE I**  
**Estimated Incidence of Cancer in**  
**North Carolina Children**

	Rate/100,000 Children/Year	Number of New Cases Annually
Leukemia	3.60	65
Brain Tumor	1.80	33
Lymphoma	1.21	22
Neuroblastoma	0.88	16
Wilms' Tumor	0.79	14
Soft Tissue Sarcoma	0.60	11
Bone Tumor	0.47	8
Miscellaneous	1.23	21
Total	10.58	190

impermeable to antileukemic drugs given by mouth or injection, the CNS can become a sanctuary for the multiplication of leukemic cells. With the improved survival of children with leukemia, the risk of CNS involvement rises to 50%-60% so specific prophylactic CNS therapy has become mandatory. Today fewer than 5% of leukemic children remaining free of other clinical disease will develop CNS leukemia.

Investigators are studying whether therapy can be more individualized so that children with a more favorable prognosis can be effectively treated less aggressively and those with more resistant disease treated more vigorously. Patients with marked leukocytosis at diagnosis, very young or adolescent patients, and those whose leukemic cells have membrane features of T or B lymphocytes appear to have a poorer prognosis and should be treated aggressively, although the best regimen remains to be determined.

Many questions arise as a result of the prolonged survival of children with ALL. Among these are the long-term effects of both the ordinarily administered antileukemic agents and the central nervous system therapy.

### ACUTE MYELOGENOUS LEUKEMIA

Patients with acute myelogenous leukemia have not experienced either the high remission rate or the prolonged survival noted for children with ALL. Drugs useful in this disease include daunomycin, doxorubicin with cytosine arabino-

side, or the combination known as POMP (prednisone/vincristine/methotrexate/6-mercaptopurine). Maintenance therapy usually includes a combination of the above agents with the addition of 6-thioguanine or continued POMP. Although remission occurs in 50%-60% of patients, the duration of survival is only 9-12 months.

The treatment of acute leukemia by bone marrow transplantation is still experimental. Most success has been obtained using marrow from an identical twin or a carefully matched non-twin sibling. Transplantation is being employed more frequently in patients with acute myelogenous leukemia, since chemotherapy remains inadequate for most patients.

### CHILDHOOD LYMPHOMA

The lymphomas of childhood — Hodgkin's disease and the non-Hodgkin's lymphomas — are contrasting diseases with regard to their behavior and management. The two types occur with about equal frequency — Hodgkin's disease in children resembling that disease in adults and non-Hodgkin's lymphoma behaving more aggressively in children than in adults. Whereas the approach to patients with Hodgkin's disease is well defined as to staging, treatment and prognosis (Table II), the approach and outlook for patients with non-Hodgkin's lymphoma is neither as precise nor as optimistic.

Hodgkin's disease is rare in children under 5, with the incidence increasing with age. In the first decade of life, it occurs predominantly in males, with the cell type usually indicative of nodular sclerosis. Clinical staging with lymphangiography and exploratory laparotomy including splenectomy is usually performed, but some disagreement exists about the necessity for these procedures in patients without systemic symptoms who have Stage disease or mediastinal disease of the nodular sclerosing histologic type. The cure rate in patients with Stage I and II Hodgkin's disease approaches 85% using radiation therapy alone. The use of extended versus involved-field radiation and the combination of this with chemotherapy is being studied for all stages of the disease, in hopes of limiting unnecessary radiation while treating occult disease effectively.

The histologic nomenclature and the value of staging are not as well established in the non-Hodgkin's lymphomas. Abdominal and mediastinal lymphoma are associated with a particularly poor prognosis despite aggressive therapy, with the latter developing into a leukemia-like illness in a high percentage of patients. Lymphoma occurring in the head and neck appears to have a better prognosis. Programs using multiple drugs plus radiation therapy do give a high initial response rate in all patients, but the

**TABLE II**  
**Hodgkin's Disease: Staging Classification**

Stage	Symptoms
A	No systemic symptoms
B	Systemic symptoms Classification as symptomatic (category B) requires one or more of the following features: (1) unexplained weight loss of more than 10% six months prior to admission, (2) unexplained fever with temperatures above 38°C, or (3) night sweats.
Stage	Extent of Involvement
I	Involvement of a single lymph node region (I) or of a single extralymphatic organ or site (I <sub>e</sub> ).
II	Involvement of two or more lymph node regions on the same side of the diaphragm (II) or localized involvement of extralymphatic organ or site and of one or more lymph node regions on the same side of the diaphragm (II <sub>e</sub> ).
III	Involvement of lymph node regions on both sides of the diaphragm (III), which may also be accompanied by localized involvement of extralymphatic organ or site (III <sub>e</sub> ) or by involvement of the spleen (III <sub>s</sub> ), or both (III <sub>es</sub> ).
IV	Diffuse or disseminated involvement of one or more extralymphatic organs or tissues with or without associated lymph node enlargement. The reason for classifying the patient as Stage IV should be identified further by defining site by symbols.



long-term outlook for patients with non-Hodgkin's lymphoma remains guarded.

## WILMS' TUMOR

The excellent outlook for children with Wilms' tumor results from the use of surgery, irradiation and chemotherapy in a multimodal attack. This approach has resulted in the formulation of many of the basic principles of pediatric oncology which direct our efforts against most of the solid tumors of childhood. From the 1940s with the advent of techniques for radical nephrectomy in small patients, followed in the early 1950s by local irradiation therapy to the empty tumor bed and in 1956 by the first successful use of a chemotherapeutic agent (dactinomycin) in Wilms' tumor patients, survival rates have improved to well over 50% for all patients.

Later it was shown that repeated courses of dactinomycin were more effective than a single course and that vincristine was as effective as dactinomycin. Thus, by the late 1960s surgery, irradiation and these two chemotherapeutic agents had been demonstrated clearly effective in Wilms' tumor patients. But there was a great need to further refine therapy for the individual child in order to avoid excessive or inadequate treatment.

A large cooperative study, National Wilms' Tumor Study I (NWTs I), begun in 1969 and completed in 1976, showed that for children under 2 years of age with tumor confined to the kidney (Group I), no benefit resulted from local irradiation when added to surgery and postoperative chemotherapy (Table II). Disease-free survival with or without irradiation was about 90%. Thus, these children can be spared the additional toxicity of irradiation. For children with tumor extending beyond the kidney but completely resected (Group II), or for those with residual abdominal tumor after surgery (Group III), the study also demonstrated an obvious superiority of the combination of dactinomycin and vincristine over either drug alone. The two-year disease-free survival was approxi-

mately 50% for children treated with either drug but was 80% in those treated with the combination. Other factors such as tumor histology also affect prognosis and will permit further refinement of initial staging and subsequent therapy.

National Wilms' Tumor Study II, now in progress, is directing attention to the effects of shortening the period of postoperative chemotherapy for children in Group I and the potential benefit of adding adriamycin, a drug recently shown to be highly effective in patients with this tumor, to the vincristine-dactinomycin regimen for children in Groups II and III. The completion of such studies is essential if children are to be offered the most effective therapy with minimal chance for acute or residual side effects from treatment.

## NEUROBLASTOMA

The prognosis for children with neuroblastoma is strongly influenced by age and the extent or stage of disease at diagnosis. The most important and as yet unexplained influence appears to be the age of the child. A typical series showed that 74% of children diagnosed between 0 and 12 months of age survived disease-free for two years while there was a rapid decrease in survival to 26% for ages 12 to 24 months and to 12% for children older than 24 months. While this difference is explained in part by the fact that very young children more

commonly have localized tumor at diagnosis, the infant with more advanced disease can be expected to fare better than older children.

Staging for neuroblastoma remains imperfect and there is currently no single staging system that is accepted by all investigators. The following system is most frequently employed:

Stage I. Tumor confined to the organ or structure of origin.

Stage II. Tumor extending in continuity beyond the organ or structure of origin but not crossing the midline. Regional lymph nodes on the ipsilateral side may be involved.

Stage III. Tumor extending in continuity beyond the midline. Regional lymph nodes may be involved bilaterally.

Stage IV. Remote disease involving skeleton, organs, soft tissues, distant lymph node groups, etc.

Stage IV-S. Patients who would otherwise be Stage I or II, but who have remote disease confined to liver, skin or bone marrow (without evidence of actual bone involvement).

While prognosis according to stage is also strongly influenced by the age of the child, children of any age with well-localized tumor (Stages I and II) have an excellent chance of survival. Children with Stage IV-S neuroblastoma are a special category. Typically they are very young and have small primary

TABLE III  
Clinical Grouping in Wilms' Tumor\*

The clinical group decided by the surgeon and confirmed by the pathologist, is determined according to the following criteria:

GROUP I — Tumor limited to kidney and completely resected. The surface of the renal capsule is intact. The tumor was not ruptured before or during removal. There is no residual tumor apparent beyond the margins of resection.

GROUP II — Tumor extends beyond the kidney but is completely resected.

There is local extension of the tumor, i.e., penetration beyond the pseudocapsule into the peri-renal soft tissues, or peri-aortic lymph node involvement. The renal vessel outside the kidney substance is infiltrated or contains tumor thrombus. There is no residual tumor apparent beyond the margins of resection.

GROUP III — Residual non-hematogenous tumor confined to abdomen.

Any one or more of the following occur:

The tumor has ruptured before or during surgery, or a biopsy has been performed.

Implants are found on peritoneal surfaces.

Lymph nodes are involved beyond the abdominal peri-aortic chains.

The tumor is not completely resectable because of local infiltration into vital structures.

GROUP IV — Hematogenous metastases.

Deposits beyond GROUP III, e.g., lung, liver, bone and brain.

GROUP V — Bilateral renal involvement either initially or subsequently.

\*From National Wilms' Tumor Study.

tumors with major distant involvement confined to liver and/or skin and with minimal bone marrow involvement. For reasons yet unexplained, these children survive almost as frequently as children with well localized tumor. Children with more advanced regional tumor (Stage III) and metastatic disease (Stage IV) have an overall survival of about 20%. Unfortunately, two-thirds of children are found at diagnosis to have disseminated disease. Therefore, while the outlook for children with localized disease is extremely favorable, the great majority of children are not so fortunate and neuroblastoma remains one of the most troublesome of the childhood tumors.

Since neuroblastoma is so enigmatic and survival is so strongly influenced by age and stage of the disease at diagnosis, recommendations for therapy are not nearly as easy as with Wilms' tumor. However, it appears that children with Stage I and II disease have an excellent chance of survival with surgery alone and that postoperative irradiation and/or chemotherapy are unnecessary. On the other hand, children with Stage III disease, especially those with residual tumor after surgery, may benefit from local irradiation and/or drug administration.

Children with Stage IV tumors, which are a common presentation, have a very poor prognosis despite aggressive attack with irradiation and combination chemotherapy. Surgical removal of the primary tumor in these children is of doubtful benefit and irradiation does not seem beneficial except for palliation of painful metastatic disease. Several aggressive multi-agent chemotherapy programs are being evaluated for the treatment of children with Stage IV tumors. Agents being tested include vincristine, cyclophosphamide and adriamycin along with some of less certain usefulness such as daunomycin, VM-26, papaverine, tri-fluoromethyl-deoxyuridine, and imidazole carboxamide. Many of these regimens may effect regression of neuroblastoma but there is no compelling evidence that they

have had a significant impact on survival.

Since spontaneous tumor regression is frequent in young children with Stage IV-S disease, many require little active treatment. If the liver becomes large enough to create mechanical problems, a short course of chemotherapy or low dose irradiation may be of benefit. In addition, chemotherapy is generally recommended for those babies with more extensive bone marrow involvement.

Neuroblastoma remains an extremely difficult problem for the pediatric oncologist. Further investigation to identify the factors responsible for its enigmatic behavior and continued trials with new agents and combinations of agents are essential if the outlook for these children is to be improved.

### BONE TUMORS

Osteosarcoma and Ewing's sarcoma are the two most common types of primary bone cancer which occur in children. Osteosarcoma is more common with the peak incidence in the 10-25-year age group. In about 60% of patients, it originates in the distal femur or proximal tibia while another 20% have their initial tumor in the humerus or the proximal femur. The tumor arises in bone-forming tissue, radiographs showing variable degrees of osteoblastic and osteolytic change.

Patients usually complain first of a painful bony swelling. Once the diagnosis is established by careful microscopic examination of biopsy material, the removal of all involved bone is mandatory, since other forms of therapy cannot control the local primary disease.

Before effective adjuvant chemotherapy was available, approximately 80% of patients who had no evidence of disease after amputation developed distant metastases within a year, most often in the lungs. With the observation that several drugs were effective in bringing about tumor regression, several chemotherapeutic regimens were developed in an effort to destroy occult micrometastases in patients without evidence of disease after amputation. Drugs found ef-

fective include doxorubicin, methotrexate in extremely high doses followed by a course of citrovorum factor to protect normal tissues from undue methotrexate toxicity (citrovorum factor rescue), vincristine, cyclophosphamide and phenylalanine mustard. Before the widespread use of adjuvant chemotherapy, the survival rate after amputation was 15%-20%, a dismal figure. With the use of adjuvant chemotherapy, a marked improvement in survival has occurred. The overall disease-free survival rate for patients treated with multiple drug therapy ranges from 50% (period of observation greater than four years) to about 75% (patients followed for at least 18 months and receiving in sequence all of the drugs described above).

Unfortunately, patients who develop metastatic disease have a much poorer outlook, although excision of visible tumor followed by aggressive multiple-drug chemotherapy is leading to long-term disease-free survival in a small but increasing portion of these patients.

Ewing's sarcoma is a primary non-osseous tumor involving bone. This tumor occurs most often in children and young adults, with 70% of patients being under 20 years of age at diagnosis. The radiographic features are not specific, and the diagnosis is established only by careful examination of biopsy material.

Unlike osteosarcoma, Ewing's sarcoma is responsive to radiation and chemotherapy, allowing preservation of function. The goals of therapy are to preserve function while destroying the primary tumor and to eradicate microscopic metastases. Since about 90% of the patients have occult metastatic disease at diagnosis, aggressive efforts to eradicate metastases are mandatory.

Amputation of the primary tumor can usually be avoided and pretreatment with chemotherapy, followed by radiation therapy to 6000 rads, then long-term chemotherapy, is effective in destroying both local and distant disease. The most useful drugs appear to be vincristine, dactinomycin, cyclophosphamide and



doxorubicin, used in varying combinations.

Metastatic disease usually involves the lungs or bony sites; generally patients are responsive to aggressive chemotherapy, plus radiation therapy to the lungs or to the primary site.

Because of the relative infrequency of Ewing's sarcoma, a national cooperative study was initiated in January 1975 to determine the efficacy of aggressive radiation therapy plus three- or four-drug chemotherapy. Although no results from this study have been published, preliminary data suggest that disease involving the ribs or the long bones is well-managed, while pelvic disease remains more resistant to therapy.

Before aggressive chemotherapy and radiation therapy, the five-year survival of patients with Ewing's sarcoma was less than 20%. Now, several small groups of patients have achieved long-term, disease-free survival which approaches 50% at five years. We await the final results of the Intergroup Ewing's Sarcoma Study to better define response rate.

## RHABDOMYOSARCOMA

Rhabdomyosarcoma, a malignancy of striated muscle, histologically identifiable as embryonal, alveolar, pleomorphic, or mixed types, is the most common soft tissue sarcoma of children. Most often seen is embryonal rhabdomyosarcoma, usually found in the head and

neck, abdomen or genitourinary tract. Alveolar rhabdomyosarcoma most often occurs in an extremity.

The patient with rhabdomyosarcoma usually complains of painless swelling of soft tissue, most often in the head and neck (35%), on the extremities (24%), in the genitourinary tract (18%), or of the trunk (11%). Often the pathologic diagnosis of rhabdomyosarcoma is difficult, sometimes requiring multiple biopsies and evaluation using an electron microscope.

The tumor has a high propensity for lymphatic or hematogenous spread. Since it is sensitive to radiation, radical surgery is usually inappropriate if the operative procedure would lead to loss of important function. For example, orbital rhabdomyosarcoma is best treated by incisional biopsy, followed by radiation therapy and chemotherapy, without sacrificing the eye in an effort to remove all local disease. However, prostatic rhabdomyosarcoma is best treated by anterior exenteration, with diversion of the ureters to an ileal conduit.

Once the diagnosis is established and total excision done when possible, therapy depends upon the extent of tumor. As a result of the Intergroup Rhabdomyosarcoma Study initiated in 1972, some prediction as to response to therapy can be made. Patients with Stage I disease (localized and completely resected) respond well to vincristine, dactinomycin and cyclophos-

phamide administered for two years. Stage II disease (microscopic residual disease with or without nodal involvement) is best treated with radiation therapy to the tumor bed, followed by vincristine plus dactinomycin, with or without additional cyclophosphamide. Stage III disease (residual gross disease) also requires localized radiation therapy plus systemic chemotherapy, including vincristine, dactinomycin and cyclophosphamide, with or without doxorubicin. Patients with Stage IV disease (metastases present at diagnosis) are treated in the same manner as Stage III patients but without such good success. Overall results for disease-free survival are as follows: Stage I disease — 92% (median follow-up 72 weeks); Stage II disease — 85% (median follow-up 45 weeks); Stage III disease — 69% (median follow-up 44 weeks). Half of the patients with Stage IV disease were alive 44 weeks after diagnosis. While these results are promising, new programs are being developed for patients with each stage of disease.

## SUMMARY

While cancer is still the leading cause of death by disease for children from age 1 to 15, the outlook for a child with cancer has improved immensely during the last 10 years. All children with cancer can benefit from these therapeutic advances, and with proper help, as many as half of them can overcome their disease.

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... So this stinking smoake being sucked up by the Nose, and imprisoned in the colde and moyst braines, is by their colde and wett facultie, turned and cast foorth againe in waterie distillations, and so are you made free and purged of nothing, but that wherewith you wilfully burdened yourselves: and therefore are you no wiser in taking *Tobacco* for purging you of distillations, then if for preventing the Cholike you would take all kinde of windie meates and drinkes, and for preventing the Stone, you would take all kinde of meates and drinkes, that would breede gravell in the Kidneys, and then when you were forced to avoyde much winde out of your stomacke, and much gravell in your Urine, that you should attribute the thanke thereof to such nourishments as bred those within you, that behoved either to be expelled by the force of nature, or you to have *burst at the broad side*, as the Proverbe is. — *A Counter-Blaste to Tobacco*, King James I, 1604.

# California Virus Encephalitis in North Carolina

Doris S. Kelsey, M.D., and Baldwin Smith, M.D.

**ABSTRACT** The occurrence of four cases of California virus encephalitis in North Carolina is reported and a case history presented. A review of the clinical findings and pertinent epidemiologic data is given to alert the clinician to the possible presence of this viral pathogen.

FOUR cases of California virus encephalitis were diagnosed in North Carolina in the summer of 1977, the first known occurrence of this infection in the state since 1965. This report reviews the clinical features of this disease by presenting a case of California virus encephalitis and discussing the emerging importance of California viruses in central nervous system disease in order to alert clinicians to an endemic foci of the virus in North Carolina.

## CASE REPORT

A 7-year-old white male from Waynesville had just returned from vacationing in the Great Smoky Mountains National Park area when he became ill in August, 1977.

A few days later, he developed severe bifrontal headaches followed by fever, nausea and vomiting.

The progressive symptomatology prompted his admission to a local hospital where he developed generalized seizure activity and then auditory and visual hallucinations. After one seizure he experienced a brief respiratory arrest. He subsequently developed a transient aphasia for four days and an associated right facial weakness. At this time he was also found to have bilateral positive plantar responses.

Initial laboratory studies included a hemoglobin of 13.0 g/dl, peripheral leukocyte count of 17,000/cu mm with an increase in polymorphonuclear cells on differential count. Urinalysis was normal. Serum electrolytes, liver function and glucose were within the normal limits. Weil-Felix agglutinations were negative except for a protein OX-K titer of 40. Cerebrospinal fluid (CSF) examination revealed no abnormalities except for a protein of 67 mg/dl. Bacterial CSF and blood cultures obtained on admission revealed no pathogens.

Electroencephalogram was interpreted as markedly abnormal with high amplitude showing especially pronounced over the right frontal region. There was also a hypodense region in this area on brain scan. The CT scan was normal.

During his hospitalization the child developed massive gastrointestinal bleeding with the hemoglobin falling to 6 g/dl and hematocrit 17.5 volumes%. This was attributed to the development of a stress ulcer.

In early September, he was transferred to the Progressive Care Unit of the North Carolina Baptist Hospital with a four-week history of an encephalitic process. At this time he had improved considerably. Seizure control had been achieved with anticonvulsants (phenytoin and carbamazepine). He was normotensive and afebrile. Height was 48½ inches and weight 60 pounds. Physical examination was normal except for motor apraxia of the left hand and a gross deficit in bimanual alternating coordination. Neuropsychological evaluation revealed a residual deficit in fine motor ability and memory with focal loss of abstract concept formation compatible with a focal frontal lobe finding. Other cortical functions were judged to be within normal limits. The Wechsler verbal IQ was 86 and performance IQ, 106. Repeat EEG at this time was compatible with a diffuse encephalopathy. Urinary screen for heavy metals was negative. Urinary amino acids were within normal limits. Serologic diagnosis of California virus encephalitis was

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made through the virology laboratory of the North Carolina State Laboratory and confirmed by the Arbovirus Reference Branch of the Center for Disease Control.

The results of serologic titers are indicated below:

CALIFORNIA VIRUS (LA CROSSE STRAIN) SEROLOGIC TESTS		
Serum Dated	Hemagglutination Inhibition Titers	Neutralizing Titers
8/19/77	20	40
9/1/77	80	320
9/16/77	80	320

On a follow-up visit three months later the child had continued to show improvement.

### COMMENT

The prototype strain of California encephalitis virus was isolated in 1943<sup>1</sup> but the significance of this member of the arbovirus group in producing widespread disease geographically was not recognized until the 1960s.<sup>2</sup> At that time several states recognized evidence of California virus activity and in 1964 a small epidemic occurred in Indiana with 11 children diagnosed as having central nervous system disease secondary to this agent. Four cases of California virus encephalitis were diagnosed in North Carolina in 1964-65.<sup>3</sup> The importance of this virus as a cause of encephalitis is reflected by the recognition of more than 500 cases in the United States during the past decade.<sup>4</sup>

The arbovirus encephalitides are zoonoses with the life cycle of the virus involving multiplication in both the arthropod vectors and vertebrate hosts. In the California virus life cycle, the usual arthropod vector is the *Aedes* mosquito group (most commonly *Aedes triseriatus*), a tree-hole breeding mosquito. Chipmunks and gray squirrels are considered the most frequent amplifying vertebrate hosts for the virus.<sup>2</sup> The infection of man is not important to the survival of the virus in nature and is probably incidental when man comes in contact with an infective mosquito.

Most of the cases of California virus encephalitis in the United

States are caused by the La Crosse strain.<sup>5</sup> Once this virus has been detected in a specific geographical area, the continuing presence of the virus in subsequent seasons can usually be demonstrated.<sup>4</sup>

To date eight cases of California virus encephalitis have been confirmed in North Carolina (Table 1).<sup>3</sup> All patients had been in the Cherokee Indian Reservation and Great Smoky Mountains National Park area just before their illnesses. This clustering of cases may be explained by the epidemiologic studies of the disease. The *Aedes* mosquito is a tree-hole breeding mosquito. Its range of flight from the breeding site is very limited so a small geographic area where mosquitoes are found serves as a site of potential infectivity. The reason for the 12-year time lapse in the occurrence of California encephalitis in North Carolina is not apparent. It could be the failure to recognize the agent as etiologic of encephalitis.

Clinical disease with evidence of central nervous system involvement occurs almost exclusively in children, mostly from 5 to 9 years of age.<sup>5</sup> Adults in endemic areas have been found to demonstrate seroconversion without apparent clinical illness. Some respiratory disease and flu-like illness in Europe have been attributed to the California group of viruses, especially the Tayna strain.<sup>2</sup>

The patient presented is representative of the severe central nervous system disease associated with this agent. Bifrontal headaches are frequently the presenting complaint and may appear a day or two

before the fever. Nausea and vomiting followed by lethargy and somnolence often become apparent as the symptomatology progresses. There may be definite meningeal signs. Other neurologic abnormalities observed include abnormal reflexes, plantar responses, transient aphasia and paralysis. Neurologic focal findings have been reported in approximately 20% of children with California encephalitis with electroencephalograms indicating evidence of focal neural dysfunction in about 40% of patients.<sup>6</sup> Serious sequelae have been reported infrequently by most investigators although prolonged clinical residua in 17 of 35 children have been observed.<sup>7</sup>

Peripheral leukocyte counts are often moderately elevated with an increase in polymorphonuclear cells, as demonstrated in this case. The cerebrospinal fluid generally reveals a pleocytosis, predominantly polymorphonuclear early and later lymphocytic. Reported cell counts have varied from 35-922/cu mm. CSF glucose is usually normal and protein may be moderately elevated.<sup>5,6</sup>

The definitive diagnosis depends on serologic testing for specific antibody. The hemagglutination inhibition and neutralizing titers rise early in the course of the illness and usually stay high for more than a year. Complement fixation titers develop somewhat more slowly and decrease more rapidly; consequently, they may be the most useful in demonstrating a fourfold diagnostic rise in titer.<sup>5</sup>

Although these signs and

TABLE 1\*  
North Carolina California Encephalitis Cases

Date of onset:	Age:	Sex:	Residence:
Aug. 7, 1964	7	M	Cherokee Indian Reservation
Aug. 17, 1965	8	M	Florida*
Aug. 17, 1965	9	F	Florida*
Sept. 21, 1965	12	F	Cherokee Indian Reservation
June 24, 1977†	5	F	Cherokee Indian Reservation
July 1, 1977†	4	M	Cherokee Indian Reservation
Aug. 15, 1977	7	M	Haywood County*
Sept. 9, 1977	8	M	Cherokee Indian Reservation

\*Vacationed in Great Smoky Mountains National Park area just before becoming ill.

†Siblings.

\*Reference<sup>3</sup>

symptoms are not unique to this agent, a combination of factors should alert the clinician to the possible presence of this viral pathogen. These include compatible clinical findings, especially in children 5 to 9 years of age, seasonal incidence (summer), and history of travel or residence in a known area of viral activity.

## ACKNOWLEDGMENT

The authors thank Dr. J. N. MacCormack, Head of the Communicable Disease Control Branch of the North Carolina Department of Human Resources, Raleigh, N.C., for providing statistical and epidemiologic information relevant to this review.

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The argument drawn from a mistaken experience, is but the more particular probation of this generall, because it is alleaged to be found true by prooffe, that by the taking of *Tobacco* divers and very many doe finde themselves cured of divers diseases as on the other part, no man ever received harme thereby. In this argument there is first a great mistaking and next a monstrous absurditie. Because peradventure when a sicke man hath had his disease at the height, hee hath at that instant taken *Tobacco*, and afterward his disease taking the naturall course of declining, and consequently the patient of recovering his health. O then the *Tobacco* forsooth, was the worker of that miracle. Beside that, it is a thing well knowne to all Physicians, that the apprehension and conceit of the patient hath by wakening and uniting the vitall spirits, and so strengthening nature, a great power and vertue, to cure divers diseases. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Editorials

## ARBOVIRAL INFECTIONS IN NORTH CAROLINA

Documentation of human arboviral (togaviral) infections in North Carolina has been infrequent. California encephalitis (CE), of which eight cases are noted by Kelsey and Smith in this issue, accounts for 30% of the serologically confirmed cases of arboviral disease reported to the N.C. Division of Health Services. One case of eastern encephalitis (EE) in 1965 and one of St. Louis encephalitis in 1975 round out the list.

These infections are probably not as rare here as the low number of reported cases might lead one to believe. Subclinical and mild arboviral infections occur far more often than illness requiring hospitalization. The infection-to-illness ratio varies with the different arboviruses, with the EE virus reportedly being the most efficient producer of disease (ratio estimated between 10:1 and 50:1). Yet compared with the serious problem of EE equine disease in coastal North Carolina in some years documented human illness has been almost nonexistent.

The etiology of many viral central nervous system infections is never documented for several reasons: attending physicians may consider viral studies as unnecessary "frill" in the management of the patient, particularly when test results may not be known until after the patient recovers; the procedures for collecting and transmitting appropriate specimens for viral studies may be unfamiliar or seem cumbersome to the clinician; or the patient who has recovered from encephalitis or aseptic meningitis may not be motivated to return two or three weeks later for submission of a convalescent serum specimen.

Of the 595 cases of aseptic meningitis, meningoencephalitis and encephalitis reported in North Carolina during the 1973-77 period, two-thirds had no record of any specimens being submitted to the Division of Health Services Laboratory for virologic studies. In these 404 cases, the reporting physician noted a probable etiologic diagnosis — presumably based on clinical grounds — in 32 instances (8%). However, in the 191 cases for which specimens were submitted, an etiologic diagnosis was reached in 96 instances (50%) based on the results of the tests. Considering the inappropriate timing of collection of many of these specimens and the problems inherent in transporting viruses in a viable state, this 50% documentation rate is perhaps not too bad. It could be better.

Aside from the points that documentation of the etiology of a patient's viral central nervous system

disease does often have clinical usefulness and that viral studies are not really so mysterious, such documentation often benefits the public health. Such is the case with the CE problem in the Smokies. There is a need to answer such questions as: Is CE geographically limited to the Great Smoky Mountain National Park-Cherokee Indian Reservation area in North Carolina? What is the risk of acquiring the infection in this area? Assuming feasibility, is some sort of mosquito control program warranted? The answers to these questions are now being sought. The quality of the answers will depend to a large extent upon the willingness of physicians who see patients with aseptic meningitis or encephalitis to seek an etiologic diagnosis.

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## LETTER FROM WILLIAMSBURG

Our world is so much with us that we occasionally need to get away, not from it all but from our pedestrian tasks so that we can see ourselves and our times in clearer perspective. Perhaps this is the reason why President D. E. Ward invited the Executive Council to assemble informally and at its own expense in Williamsburg July 27-30 of this year, to consider thoughtfully and at some leisure the current state of the North Carolina Medical Society. For all organizations and all institutions must counter the constant threat of inertia and even exhaustion by periodically deciding what is best conserved and what discarded if they are to survive. It is well and good to reconfirm the faithful but changing times demand new and more lively rituals if societies are to be strong and effective.

Colonial Williamsburg is an appropriate site for meditation. Even crossing into Virginia from North Carolina on an interstate highway helps in preparation; billboards disappear, the countryside assumes a more orderly air and the sumac blooming on the road banks seems to offer promise of something different. Of course Colonial Williamsburg is different, almost unreal because what 18th Century American town was so neat and its streets so free of pigs, the universal scavengers and ancestors of Virginia ham, now a delicacy. But shrines, holy or secular, must be neat and well-kept to assure pilgrims that their traditions are being properly, even immaculately, preserved. When the shrine itself witnessed the beginnings and the early and vigorous growth of some of those traditions, the

atmosphere becomes even more conducive to thought.

Many pilgrims come here in all seasons to learn of our historic roots, seeking perhaps that sense of purpose which many think has gone out of our government and our way of life. In the summer the South becomes crowded, in the mountains and at the shores, and the crowds pause to look at pre-Revolutionary settlements, plantation homes, pageants and Civil War memorials as well as at the trite attractions of amusement parks. But these crowds are remarkably docile particularly in the heat of Williamsburg walking on Duke of Gloucester Street unchallenged by mopeds, motorcycles or horseless carriages. Because of the heat they move slowly, almost carefully, stopping to look, question and comment. The voices, even the non-Southern ones, seem softer under the vivid crepe myrtles, and people make way for each other without snarling. When people sweat in Virginia in July, there is no point in hurrying and if hurrying is useless, one might as well accept it and be polite.

Such an environment must have encouraged the early Virginians to seek a comfortable common ground as they learned to govern themselves, developing a system which when sharpened slightly by the tart New England mind provided the philosophic support of this new nation. Perhaps they even recognized that a little dullness is sometimes a necessity in public life to prevent passionate states of mind.

The Virginians who sat at the House of Burgesses at the end of Duke of Gloucester Street and who revelled after hours at the Raleigh Tavern and elsewhere would have been at home in our sessions, both serious and playful, at the Williamsburg Lodge. They would have agreed with Bruce Balfé who came from Chicago to bring word from the AMA when he listed the continuing purposes of organized medicine.

1. To federate and unify the profession
2. To extend medical knowledge and advance medical science
3. To elevate the standards of medical education
4. To elevate the standards of medical service, and
5. To inform the public.

Mr. Jefferson and George Wythe, his law teacher at William and Mary whose house faces the Palace Green, would have well understood these aims and would have been particularly appreciative of the care taken in our sessions that these points be carefully and separately considered. They would have recognized that we must beware of the pitfalls of common purpose which can make all of us assume at times that our way is the right way and the only way. In this vein there is particular concern that the Executive Council should be more widely representative of the Society, that entry into our corridors of action should be easier particularly for new members and that all segments of the public even including physicians and legislators be better informed about the many facets of modern medicine.

Mr. Jefferson would not have been surprised at the number and diversity of topics covered in our deliber-

ations for his mind was as scientific as it was practical. Devoted as he was to the development of industry, the improvement of agriculture and a better life for the "yeomen", he appreciated the need for system while full well knowing that people can be enslaved by the systems governments devise. Since he had sat at the first great committee of these United States which had been enjoined to write what became the Declaration of Independence, he would have been concerned as we about our commissions and committees, how they are constituted, what they do and why, when and how they might be eliminated.

Our founding fathers wrote and wrote and wrote to sway and convince because in those days the franchise was limited and few of the illiterate could vote. They composed the Federalist Papers which took the issue of the constitution to the people and to the state legislature. They would have understood our need to present our position to today's public and today's legislators and would not have been horrified that medicine has found it necessary to have effective spokesmen in Washington and in the state capitols. As they did, we decry faction while recognizing that factions must be listened to if the common good is to be realized through individual and community actions or through legislation. For the process never stops and those with fetishes for secrecy cannot endure when each faction can in its turn become a watchdog for the common welfare.

If the process never stops, it is because in a democracy, whether national or professional, leaders must emerge with each generation. How to recognize the leaders of tomorrow and how to prepare them today for that tomorrow remain as important now as 200 years ago yet our ways to do this seem to have improved little since the gentlemen of Virginia and their colleagues somehow got us off to such a good start.

Colonial Williamsburg time is different from modern and that is one of its great attractions. The pressures of today are less forceful and the limping dollar seems less important, if only for a moment, when we are possessed by that ancient rhythm. The era of the artisan, the journeyman painter, the itinerant mechanic can be almost recaptured — especially across the street from the lodge at the Abby Aldrich Rockefeller Folk Art Collection where the talents of weavers, dyers, tinsmiths, carvers, quilters, anonymous and obscure, and artists as well known as Grandma Moses and Edward Hicks can be enjoyed. There is even a Carolina Room there with pine wood paneling painted by one "J Scott/August 18, 1836" in Wagram in Scotland County. Across the street in the Lodge those of us making a Carolina Room of our own did not need to be reminded that we are responsible for the traditions of a great profession and for the advancement of its arts and science — for constructive continuity. But Williamsburg reminds us that we are custodians of a culture too for which we must fulfill these responsibilities and which we must preserve for tomorrow's patients and physicians. These were our Williamsburg resolves.

J.H.F.



# Committees and Organizations

## COMMITTEE ON DRUG ABUSE

The Medical Society Committee on Drug Abuse has met with representatives of the North Carolina Pharmaceutical Association to discuss matters of common interest and concern. Some important facts about prescribing were elicited; physicians are urged to read and refer to the following information and suggestions:

The SBI says that one pad of your prescription blanks will fetch at least \$50 on the black market. Warn your staff about this. Keep prescription blanks in a safe place where they can't be stolen easily. Minimize the number of Rx pads in use.

According to a recent story in the *Asheville Citizen*, prescription-forging is likely to be done by a middle income housewife with several children. Nationwide, an estimated 11 million people are involved with drugs such as Darvon®, Ionamin®, Hycomine®, Preludin® and Dilaudid®.

Page Hudson, M.D., chief medical examiner for the state, says that propoxyphene (Darvon®) causes more drug deaths in North Carolina than any other chemical substance after alcohol and carbon monoxide. He also reports a considerable increase in the number of deaths due to the tricyclic antidepressants, amitriptyline (Elavil®, Endep®) of late.

Do not renew prescriptions automatically on request. If the pharmacist calls, you can agree to his dispensing enough for a day or two but ask him to tell the patient that you cannot renew the prescription without a visit and examination. This protects you and the patient.

When a pharmacist calls, instruct your staff to put him through to you at once whenever possible. He may be trying to verify a forged prescription and if he cannot reach you the forger may not be apprehended.

Tell your employees to identify themselves by name if calling a pharmacist on your behalf. This is in addition to giving your name.

Write prescriptions for Schedule II drugs in ink or indelible pencil or use a typewriter. They must be signed by you and only you. Write out the actual amount prescribed in words in addition to giving an Arabic number or Roman numeral.

Avoid writing prescriptions for large quantities of controlled drugs unless you absolutely determine that such quantities are necessary.

Be cautious when a patient says that another physician has been prescribing a controlled drug. Consult

the physician or the hospital record or examine the patient thoroughly and decide for yourself if a controlled drug should be prescribed.

Prescription blanks should be used for only writing prescriptions — not for notes or memos. A drug abuser could easily erase the message and use the blank to forge a prescription.

Never pre-sign blank prescription pads or have anyone else in your office sign for you. To do so exposes you to legal charges.

Check the refill option — do not leave blank.

Write (or have printed) on your Rx pads "refill on schedule." In the absence of a statement such as this, the pharmacist may be forced by the patient to issue refills in excess of a reasonable frequency.

Encourage patients to use the same pharmacy. That way a medication record card will be available if you need to review his drug history.

A useful phrase to consider printing on prescription pads is, "all refills will be made only during regular office hours." Under these circumstances pharmacists will not telephone you at home or try to reach you where your records are not available.

Stay within the range of your own field when it comes to prescribing. For example, a psychiatrist who prescribes a large quantity of Lomotil® for a family member going abroad is showing poor judgment, even though he may not be breaking the law.

Most drug-dependent individuals using prescription medications are suffering from an iatrogenic illness. It is our responsibility to have a high index of suspicion for this problem and not to contribute to it by prescribing so freely. Some drug-dependent individuals will require hospitalization and a complete change of attitude.

According to the American Medical Association News of 3/27/78 there are believed to be between 200 to 1,000 "scrip doctors" in California alone. These are M.D.s who sell prescriptions for more than 90% of the drugs sold on the black market. Their prescriptions are for substances such as Ritalin®, Quaalude®, Seconal®, Biphedamine®, Percodan®, Desoxyn®, Valium®, Preludin®, Demerol®, Dexedrine®, Dilaudid® and Nembutal®. Many are being charged with prescribing or dispensing for non-medical purposes. How many "scrip doctors" are there in North Carolina? Some are known to, or suspected by, the State Bureau of Investigation. Do not take the risk of joining the group.

The N.C. Pharmaceutical Association is developing a statewide alert system for prescription forgeries. Please help your pharmacist colleagues in all ways possible.

The Medical Society Committee on Drug Abuse

welcomes information from fellow physicians about these issues and suggestions of other approaches the committee might take to help to reduce the toll of drug abuse.

JOHN A. EWING, M.D., Chairman

## Bulletin Board

### NEW MEMBERS of the State Society

Benjamin, Sanford Philip, MD (PTH) 5623 McAlpine Farm Rd., Charlotte 28211  
Bustard, Victor William, MD, (OBG) 703 Professional Dr., New Bern 28560  
Champion, Lawrence, MD, 100 Eastowne Drive, Chapel Hill 27514  
Clark, William Mackey, MD, (R) 1704-A Roxborough Rd., Charlotte 28211  
Davis, Timothy Eugene, MD, (GS) 1100 Olive St., Greensboro 27401  
Ferry, Seneca Taylor, II, MD, (FP) Family Medicine Ctr., Sea Level 28577  
Foulks, Gary Neal, MD, (OPH) 3425 Dover Road, Durham 27707  
Frakes, James Terry, MD, (INTERN-RESIDENT) 209 Creek's Edge, Polk's Landing, Box 20, Chapel Hill 27514  
Gaither, Ronald Spencer, MD, (OBG) 100 Sunnybrook Rd. Ste. 102, Raleigh 27610  
Galloway, James Madison, Jr., MD, (FP) 118 Oakmont Prof. Plaza, Greenville 27834  
Gallup, Kenneth Raynor, Jr., MD, (PUD) Bermuda Run, Box 731, Advance 27006  
Halperin, Alan Keith, MD, (GP) 207 Arlington Drive, Greenville 27834  
Haywood, Bertron Don, MD, (OBG) 100 Sunnybrook Rd. Ste. 102, Raleigh 27610  
Hosseinian, Mahmood, MD, (AN) 149 Providence Square Dr., Charlotte 28211  
Kane, Richard Douglas, MD, (U) 3900 Browning Place, Raleigh 27609  
Kelly, Jean Alexandra, MD, (DR) 1109 Mashie Lane, Rocky Mount 27801  
Lipscomb, Larry George, MD, (INTERN-RESIDENT) 1407 Norton St., Durham 27705  
Locklear, Kenneth Edward (STUDENT) Crestwood Mobile Park, Box 20, Chapel Hill 27514  
MacDonald, William Webster, MD, (OBG) 1023 Edgehill Dr., Charlotte 28203  
Metzger, George Andrew, MD, (IM) 315-A Mulberry St., SW, P.O. Box 1020, Lenoir 28645  
Monson, Robert Charles, II, MD, (GS) 5233 Camilla Dr., Charlotte 28211  
Morgan, Richard Earl, MD (GS) 403 Melody Lane, New Bern 28560  
Orison, William Gresham, MD, (OPH) 2203 S. Sterling St., Morganton 28655  
Phelps, James S., Jr., MD, 1850 E. Third St., Charlotte 28204  
Ramsey, Edward Allison, MD, (PD) 124 Foye Drive, Rocky Mount 27801  
Rostand, Robert Alton, MD, (IM) 624 Quaker Lane, High Point 27262  
Russek, Allen Sidney, MD, 303 The Oaks, Burning Tree Dr., Chapel Hill 27514  
Sample, Franklin Robert, Jr. (STUDENT) 202 N. Oak St. Apt. #3, Greenville 27834

Sayers, Daniel Garvin, MD, (INTERN-RESIDENT) 857 Fenimore St., Winston-Salem 27103  
Smithwick, James David, MD, (PD) 709 Frederick Ave., Lenoir 28352  
Steege, John Francis, MD, (OBG) Box 3263, Duke Med. Ctr., Durham 27710  
Waller, Robert Joseph, MD, (RT) P.O. Box 2959, Asheville 28802  
Yoder, Charles Dewayne, MD, (PD) 509 Biltmore Avenue, Asheville 28801

### WHAT? WHEN? WHERE? In Continuing Education

Please note: 1. The Continuing Medical Education Programs at Bowman Gray, Duke, East Carolina and UNC Schools of Medicine, Dorothea Dix, Wayne County Hospital, Burroughs Wellcome Company and Craven County Memorial Hospital are accredited by the American Medical Association. Therefore CME programs sponsored or co-sponsored by these schools automatically qualify for AMA Category I credit toward the AMA's Physician Recognition Award, and for North Carolina Medical Society Category A credit. Where AAFP credit has been requested or obtained, this also is indicated.

2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information."

#### PROGRAMS IN NORTH CAROLINA

##### December 1-2

American College of Physicians — North Carolina Society of Internal Medicine Annual Meeting  
Place: Sheraton Inn, Charlotte  
For Information: Norman H. Garrett, M.D., 1038 Professional Village, Greensboro 27401

##### December 2

Pregnancy, Birth and Infancy: Origins of Attachment  
Fee: \$35  
Credit: 6 hours  
For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

##### December 11-15

Industrial Toxicology  
For Information: Mario Battigelli, M.D., Department of Medicine, UNC School of Medicine, Chapel Hill 27514

##### December 13

Office Gynecology  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category I



or Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January-February

st District Medical Society Postgraduate Course

Place: Edenton, Ahoskie

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### January 10

mmunological Aspects of Malignancy

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours; AMA Category I

For Information: F. M. Simmons Patterson, Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January 17

Vingate Johnson Memorial Lecture

Fee: None

Credit: 2 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### January 17

Office Recognition and Management of Sexual Dysfunction

Place: Flame Steak House, Sanford

Sponsors: Lee County Medical Society and Wake AHEC

Fee: \$6

Credit: 3.5 hours

For Information: R. S. Cline, M.D., Director of Continuing Medical Education, Lee County Hospital, Sanford 27330

#### January 26-27

Jrology Postgraduate Course

Fee: \$100

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### February 1-3

Womack Surgical Society Meeting

Place: Berryhill Hall

For Information: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill 27514

#### February 2-3

North Carolina Conference for Medical Leadership

Place: Sheraton Crabtree Motor Inn, Raleigh

Sponsor: North Carolina Medical Society

For Information: Mr. William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

#### February 14

Psychopharmacology Update

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours; AMA Category I

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### February 16-20

Basic Electroencephalography

Credit: 30 hours

For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### February 19-23

Microvascular Surgery Workshop

Credit: 40 hours

For Information: Malcolm H. Rourke, Jr., M.D., Director, Continuing Medical Education, Duke University Medical Center, Durham 27710

#### March 3-4

Anesthesiology

For Information: David Brown, M.D., Department of Anesthesiology, UNC School of Medicine, Chapel Hill 27514

#### March 8-10

Internal Medicine — 1979

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 9-10

2nd Ocutome Workshop

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### March 9-10

Frank R. Lock Symposium in Obstetrics and Gynecology

Fee: \$125

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

#### March 14

Recent Advances in Surgical Care

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours; AMA Category I

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### March 29-30

Annual Cancer Research Symposium

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

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### March 31-April 1

#### 4th Annual Radiology Update

Fee: \$50

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### April 2-6

#### 7th Annual Tutorial — Radiology of the Chest

Sponsor: The Department of Radiology, Duke University School of Medicine

Credit: 30 hours

For Information: Robert McLelland, M.D., Radiology-Box 3808, Duke University School of Medicine, Durham 27710

### April 2-6

#### Chest Radiology

Place: Ramada Inn, Durham

Fee: \$300

Credit: 30 hours

For Information: Robert McLelland, M.D., Radiology Box 3808, Duke University Medical Center, Durham 27710

### April 6-7

#### Practical Pediatrics

Fee: \$35

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### April 11

#### Current Clinical Problems in Family Practice

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours

For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

### April 12

#### Greensboro Academy of Medicine — 32nd Annual Medical Symposium

Place: Jefferson-Standard Club, Greensboro

Fee: None

Credit: 6 hours

For Information: Robert M. Gay, M.D., Moses Cone Memorial Hospital, Greensboro 27420

### April 18-20

#### Rainey Orthopedic Lectures

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine Chapel Hill 27514

### April 20-22

#### Spring Radiology Seminar

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building, 202-H, School of Medicine Chapel Hill 27514

### April 27-28

#### 12th Malignant Disease Symposium

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine Chapel Hill 27514

### April 27-28

#### Perspectives on Pain Management

Fee: \$100

Credit: 12 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### May 2-3

#### Annual Meeting of the North Carolina Thoracic Society

Place: Royal Villa, Raleigh

For Information: Mr. C. Scott Venable, Executive Director, North Carolina Lung Association, P.O. Box 127, Raleigh 27602

### May 9-10

#### Respiratory Care Symposium: Breath of Spring 1979

Fee: \$35

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27103

### May 18-19

#### 5th Annual Course in Perinatology

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine Chapel Hill 27514

## ITEMS OF SPECIAL INTEREST

### December 7-10

#### Thirty-Second American Medical Association Winter Scientific Meeting

Place: Las Vegas

For Information: Department of Meeting Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

### February 12-16

#### Current Concepts in Diagnostic Radiology

Place: Acapulco Princess Hotel, Mexico

Sponsor: Department of Radiology, Duke University Medical Center

Fee: \$250

For Information: Robert McLelland, M.D., Radiology Box 3808, Duke University Medical Center, Durham 27710

### March 5-8

#### 18th National Conference of the Detection and Treatment of Breast Cancer

Place: Atlanta, Georgia

Sponsor: American College of Radiology

For Information: American College of Radiology, 6900 Wisconsin Avenue, Chevy Chase, Maryland 20015


### May 6-10

#### 2nd International Symposium on Adolescent Medicine

Place: Mayflower Hotel, Washington, D.C.

Sponsor: The Society for Adolescent Medicine

Fee: \$150



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# **NORTH CAROLINA MEDICAL SOCIETY APPROVED INSURANCE PROGRAMS**

## ***Major Hospital and Nurse Expense Insurance***

\$25,000 maximum benefit: choice of deductibles from \$100 to \$1,000: benefits paid regardless of other insurance

## ***In Hospital Indemnity Insurance***

Benefits available from \$30 to \$75 per day: pays regardless of other insurance

## ***Excess Major Medical Insurance***

\$250,000 maximum: choice of \$15,000 or \$25,000 deductible

## ***Term Life Insurance***

Coverage from \$10,000 to \$100,000: dependents and employees eligible

## ***Business Overhead Expense Insurance***

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#### Abdominal Real Time Sonography Courses

A series of six week-long courses on the use of Real Time Ultrasound in abdominal studies will be offered at Bowman Gray School of Medicine on the following dates: December 4-8, 1978; March 12-16, June 11-15, July 16-20 and December 9-13, 1979. Participants will receive 30 hours of Category I credit per week. For further information, please contact, James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem 27103

The items listed in the above column are for the six months immediately following the month of publication. Requests for listing should be received by "WHAT? WHEN? WHERE?", P.O. Box 27167, Raleigh 27611, by the 10th of the month prior to the month in which they are to appear. A "Request for Listing" form is available on request.

## AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY

### REPORT OF THE PRESIDENT TO THE EXECUTIVE COUNCIL OF THE NORTH CAROLINA MEDICAL SOCIETY, OCTOBER 1, 1978

It is my pleasure to report to you the activities of your auxiliary during the past year and our hopes of accomplishment for the coming year.

May I first thank Dr. Estes, Dr. Ward, Dr. Pully, the committee and the entire staff of the society for their eagerness to help the auxiliary in any way possible. As you may be aware, our state newsletter, "Tar Heel Tandem" is now being printed by the headquarters staff. This accounts for the improved and professional appearance of this vital link between state and county activities. Mr. Hilliard has agreed to have our membership mailing list computerized for more efficient and economical service to our members.

Since taking office May 6, I have visited all counties who have invited me and am planning to attend the District 9 Auxiliary meeting and the District IV joint meeting. These visits have enabled me to match faces with the names on our master membership list. On each visit I have stressed the efforts of our auxiliary to assist the society in any and all projects initiated and to follow up on existing ones.

The importance of factual information on cost containment was stressed by our national auxiliary president in St. Louis. I have also stressed this on my visits around the state. We plan to have an article composed by a society officer on cost containment in our next newsletter.

Many important projects are being initiated throughout the state. I was privileged to be present at the dedication of the Buncombe County Health Adventure with Mrs. Rosalynn Carter as guest speaker. This has been a *total* effort of not only society and auxiliary members but other interested volunteers. It is a magnificent health education facility that will enable school children throughout western North Caro-

lina to learn more about their bodies and how to care for them properly.

Our total contributions for AMA-ERF were \$21,643.90 for the past fiscal year, with 75% being contributed through the Sharing Christmas Card project. This is an increase of almost \$5,000 over last year. Please remember that physicians' contribution to the medical schools of their choice may be channeled through our AMA-ERF chairman and that the auxiliary gets credit for this.

Through the diligent, joint efforts of the society and the auxiliary and the bulldogging of our past president Martha Martinat, and the late Dr. Archie Johnson House Bill 540 was passed by the N.C. Legislature June 16. As you know, this bill will establish a statewide system of School Health Education over a 10-year period. Funding has been secured for eight of 145 school administrative units. Therefore, this bill *must* be pushed during the 1979 legislative session for continued funding for the coming years.

Legislators tell us that the initial funding was secured *only* because:

1. Society and auxiliary presented a united front; this was indeed a joint endeavor. Mail-o-grams from physicians and spouses flooded the legislature during the final and crucial weekend session and turned the tide in our favor.

2. Bulldogging efforts of the auxiliary, and especially, Martha, in lobbying all sessions for H.B. 540.

In preparation for the coming session, the auxiliary plans to provide an active speakers' bureau with a training program in Raleigh. Immediate planning is vital. We will also provide a monitoring group for H.B. 540 and the other issues supported by the medical society, with your permission.

The results of such improved health education will reduce both illness and costs of medical care. This endeavor must again be a joint effort of the society and auxiliary.

Continuing with our efforts to improve health care in our state, I would like to report that in June of this year I was requested by the Department of Human Resources to chair a statewide Immunization Steering Committee to eradicate the childhood diseases of diphtheria, tetanus, pertussis, measles, rubella and mumps. At the time of this report only 82% of the children in North Carolina have proper immunizations; our goal is to bring this figure up to 95% as requested by Dr. Morrow. This means 55,000 children (ages one to four) need proper immunizations.

The objectives of this steering committee are to:

1. Set up immunization tracking systems for newborns and pre-schoolers
2. Intensify public awareness
3. Instigate hospital referrals of newborns
4. Provide assistance at preschool registration
5. Review records of day care centers and child development centers

At our last meeting, Dave Reynolds of Burroughs Wellcome Company sat in to help with our public awareness campaign. The Department of Human Re-



sources will provide materials for circulation for which I am very grateful. Since the auxiliary has contacts in each of the 100 counties, we can provide volunteers who are vitally concerned with the eradication of communicable diseases among children. I am grateful to Ann Frazier, president elect, and to Eleanor Hunt of Wilmington, our state community health chairman, who are serving with me. This project is also a top priority of the National League of Nursing.

Earlier this fall we presented a state leadership workshop for 107 enthusiastic participants. Our state theme this year, "Our Adolescents, Their Changing World," was emphasized at the workshop and is being promoted through many of our county auxiliaries. These local programs will be further enhanced by a statewide seminar to be presented in the spring by my own Forsyth County Auxiliary, co-sponsored by our state auxiliary and our society, with Dr. Ward's approval. It will be presented March 24 at Babcock Auditorium, Bowman Gray School of Medicine, Winston-Salem. We invite all interested members of the society to join us on that date. Also invited will be those in the field of counseling, both church and school.

A recent project of International Health "Interplast" is also being promoted by our group. As physicians know, this is a self-supporting project to send plastic surgeons to foreign countries to repair birth and even burn defects for children who otherwise

could not receive this care and thereby increase their chances for a normal life among normal children. This is not only a physical benefit but a psychological one. Any contributions to this worthy cause may be directed to our International Health chairman.

MRS. ROBERT L. MEANS, President

#### News Notes from the—

### EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

The ECU School of Medicine, in cooperation with Dare County and the Department of Human Resources' Office of Emergency Medical Services, has developed an emergency helicopter program for the eastern portion of the state in an effort to improve the quality of emergency health care delivery in the region.

The Eastern North Carolina Helicopter Program, modeled after military air ambulance programs, will serve 19 counties in the northeast section of the state and link 14 hospitals and seven clinics.

Medical patients who require specialized treatment may be transported by helicopter from anywhere in the region to the health care facility deemed most

## With the new HR-10 you might salt away more than \$17,000 annually

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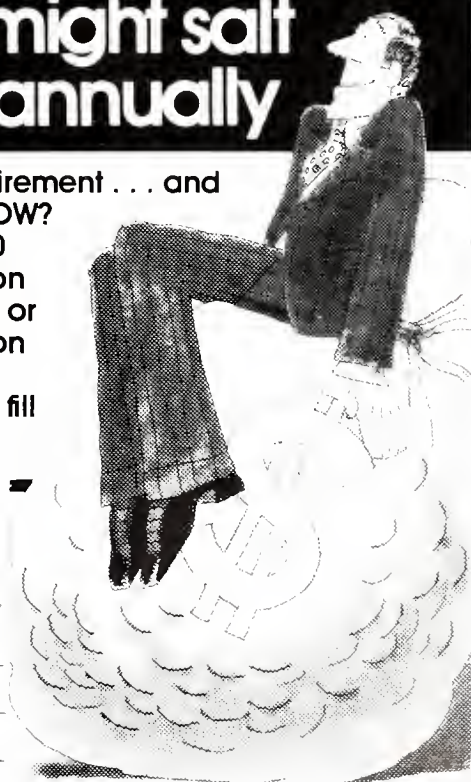
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appropriate to handle that specific case.

The program has its roots in Dare County where several years ago Sheriff Frank Cahoon developed an emergency air evacuation service for persons in the isolated Outer Banks area. An army surplus UH-1B helicopter owned by Dare County will be used for the new program. The county will also provide trained pilots, emergency medical technicians and supplies.

The School of Medicine will provide medical coordination for the program under the direction of Dr. Walter J. Pories, chairman of the ECU Department of Surgery. Pories will also direct specialized training of flight personnel.

The state EMS office will aid the program with administrative support and funds for fuel and equipment, such as oxygen, suction aspirators and an incubator.

A physician desiring to transfer a patient will call Pories at a central number at Pitt County Memorial Hospital in Greenville. Pories or a designated official will arrange for the helicopter transport and make the necessary preparations at the receiving hospital.

The program will serve Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Martin, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell and Washington counties.

\* \* \*

Dr. G. Richard Athey, a gastrointestinal physiologist, has been appointed assistant professor in the Department of Physiology. His major research interest is the nervous system of the gastrointestinal tract.

A native of Texas, Athey received his undergraduate and master's degrees from the University of Colorado. He earned his Ph.D. in physiology and pharmacology from the University of North Dakota School of Medicine.

He recently completed a National Institute of Health Postdoctoral Fellowship in the Departments of Physiology and Gastroenterology at Kansas University Medical Center.

\* \* \*

A discussion at a professional conference two years ago resulted in a meeting this summer between an East Carolina University physiologist and a Latin American biophysicist who together studied for the first time a fundamentally important cell of the nervous system and proved it was possible to examine the cell in other animals.

Dr. Edward M. Lieberman, a professor at the ECU School of Medicine, spent three months at the Venezuelan Institute for Scientific Research collaborating with Dr. Jorge Villegas, a professor of biophysics who has done extensive work on various cells of the nervous system.

For several years Lieberman has been studying the delicate balance of sodium and potassium in nerve cells, a ratio that must be maintained if nerves are to

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(diethylpropion hydrochloride NF) controlled-release

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Brief Summary

**INDICATION:** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS:** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS:** *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecostasia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSE AND ADMINISTRATION:** Tenuate (diethylpropion hydrochloride). One 25 mg. tablet three times daily, one hour before meals, and in moderation if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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**References:** 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M. A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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**Whether overweight is a  
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# **Tenuate<sup>®</sup> Dospan<sup>®</sup> <sup>IV</sup>** **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

## **A useful short-term adjunct in an indicated weight loss program.**

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

## **In uncomplicated obesity.**

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

## **Clinical effectiveness.**

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.<sup>1</sup> And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."<sup>2</sup> Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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perform properly. Villegas, on the other hand, has been concentrating on Schwann cells, small cells that surround the nerve and are particularly sensitive to neurotransmitters.

Villegas' lab is the only one in the world to have studied and recorded the electrical activity of the cell. His work had been done only with tropical squid, but he believed the results of his experiments could be duplicated with cells from other animals. Lieberman agreed and suggested the use of his laboratory model, the crayfish.

Using the same sophisticated techniques that Villegas had used on squid, the two were able to repeat for the first time Villegas' experiments on Schwann cells of the crayfish.

Lieberman is currently preparing his lab to continue the studies started this summer. His work will be funded in part by a two-year, \$74,000 grant from the National Science Foundation.

He and Villegas plan to meet again this winter back where they started — at a professional meeting where they will present the results of this summer's work to the scientific community.

\* \* \*

Dr. Gerald L. Moriarty, a psychiatrist and neurologist, has been appointed assistant professor in the Department of Psychiatry. He will direct the establishment of a family psychiatry program.

A native of Missouri, Moriarty was awarded under-

graduate and master's degrees from St. Louis University. He received his M.D. from Case Western Reserve University and completed a medical internship and residencies in neurology and psychiatry at McGill Teaching Hospitals and the University of Rochester.

Following postgraduate training, Moriarty held a faculty appointment in psychiatry at the University of Rochester.

#### News Notes from the—

### BOWMAN GRAY SCHOOL OF MEDICINE WAKE FOREST UNIVERSITY

Dallas L. Mackey, former executive with Ketchum, Inc., has been appointed director of the Office of Development at the Bowman Gray/Baptist Hospital Medical Center.

His responsibilities include the coordination and support of the medical center's fund raising activities, particularly as they relate to the private sector. He also will provide administrative support in the further development of alumni affairs.

During his 14 years with Ketchum, Inc., he served approximately 50 related college, university and hospital clients. For the past decade, he has been as-

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NIACIN .....	50mg
DIMENHYDRINATE (Dramamine) .....	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome, Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylene-tetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

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sociate manager of Ketchum's Southeastern Region with offices in Charlotte.

He was the professional consultant for the Bowman Gray/Baptist Hospital Medical Center's recent Challenge Fund, an \$18 million program to support construction of two new buildings at the medical center and to renovate specific areas in existing buildings.

\* \* \*

Dr. John Dennis Hoban has been appointed director of the Office of Educational Research and Services and associate professor of medical education at Bowman Gray. He is one of 22 fulltime and 13 part-time faculty members newly appointed at the school.

Joining the fulltime faculty are Dr. Murray P. Naditch, associate professor of psychology and head of the section on psychology and sociology in the Department of Medical Social Sciences; Dr. John W. Reed, associate professor of surgery (ophthalmology); Dr. Wayne T. Corbett, assistant professor of epidemiology; Dr. Arthur H. Hale, assistant professor of microbiology and immunology; Dr. Craig K. Henkel, assistant professor of anatomy; Dr. Timothy E. Kute, research assistant professor of medicine (hematology/oncology); Dr. Douglas S. Lyles, assistant professor of microbiology and immunology; Dr. Charles H. McLeskey, assistant professor of anesthesia; Dr. Roger W. Park, assistant professor of pediatrics; Dr. Nat E. Watson, assistant professor of radiology (nuclear medicine/ultrasound); and Dr. Neil

T. Wolfman, assistant professor of radiology (ultrasound/CT/general radiology).

Also, Dr. David A. Albertson, instructor in surgery; Dr. Venkata R. Challa, instructor in pathology (neuropathology); Dr. John H. Gilliam III, instructor in medicine (gastroenterology); Dr. Charles E. Gregg, instructor in anesthesia; George Howard, research instructor in neurology (biostatistics); Dr. Mary Virginia Lyles, instructor in medicine; Dr. David M. Taub, instructor in comparative medicine; Dr. Richard T. Urban, instructor in obstetrics and gynecology; Dr. John R. Ureda, instructor in community medicine; and Dr. Jerry Weingarten, instructor in pathology.

Joining the part-time faculty are Dr. Charles W. Lloyd, clinical professor of obstetrics and gynecology; Dr. Richard M. Orlowski, clinical assistant professor of dentistry; Dr. Jack L. Church, clinical instructor in radiology; Dr. Donald A. Dewhurst II, clinical instructor in family medicine; Dr. John A. Fagg, clinical instructor in surgery (plastic surgery); Dr. Robert S. Lawrence, clinical instructor in family medicine; Dr. Quincy A. McNeil Jr., clinical instructor in obstetrics and gynecology; Dr. John A. Myracle, clinical instructor in pediatrics; Dr. Edward H. Weaver, clinical instructor in psychiatry; Philip D. Blalock, clinical assistant in otolaryngology (speech); Jerry L. Hopping II, clinical assistant in allied health (physician assistant program); Karen J. Smuckler, clinical assistant in otolaryngology (audiology); and

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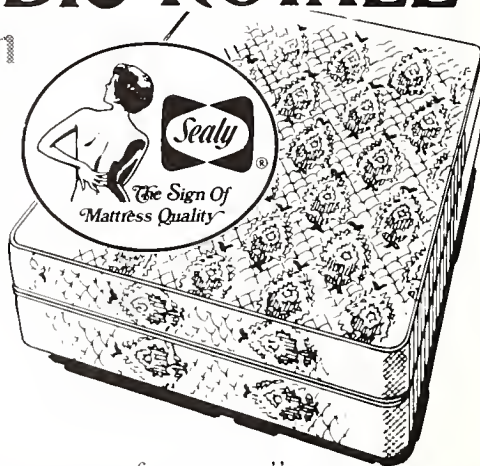
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Michael D. Walker, clinical assistant in allied health physician assistant program).

\* \* \*

Bowman Gray began a unique continuing education series for radiologists in September.

Saturday morning sessions for a six-week period are designed to cover selected areas of interests for practicing radiologists in a commuting distance of Winston-Salem.

Dr. I. Meschan, professor of radiology, is director of the series. Seminars will deal with radiology of the gastrointestinal tract, chest, urinary tract and gall bladder. One session is being devoted to computed tomography.

\* \* \*

Baxter Wynn, a resident in pastoral counseling in Baptist Hospital's School of Pastoral Care, has been named the new chaplain to students at Bowman Gray.

It is the first time in several years that the position has been made a fulltime job.

Wynn is a graduate of Southeastern Baptist Theological Seminary and Wofford College.

His goals for the chaplaincy include being available for private conversations relating to students' personal concerns, assisting students interested in medical mission opportunities, providing a forum for the discussion of ethical issues important to those involved with a medical center and providing a source of community for interested students.

Bowman Gray's ultrasound program was one of only three in the nation visited by federal officials in September to help them determine ultrasound's status in diagnosing atherosclerosis.

As a result of the visits, a report to the National Institutes of Health will be written containing recommendations on the future of research in ultrasound as it can be applied to atherosclerosis.

\* \* \*

Bowman Gray ended its six year involvement with the Farmington Medical Center in rural Davie County in October. Medical responsibility for the center has been transferred to a group of Davie County doctors in Mocksville.

Opening of the Farmington center in 1972 marked the school's first deep involvement in a rural health care delivery system centered on the use of physician extenders.

Last March, Bowman Gray ended its involvement with a similar health center, the East Bend Community Health Center. A group of Yadkinville physicians assumed medical responsibility for that center.

\* \* \*

Dr. Robert A. Diseker, associate professor of community medicine and head of the section on community medicine, has been appointed vice-chairman of the Public Education Committee of the Forsyth County Unit of the American Cancer Society.



## Saint Albans Psychiatric Hospital

An accredited private nonprofit psychiatric hospital for the treatment of all major psychiatric illnesses, including alcoholism and drug abuse, of adults and adolescents.

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Dr. Howard D. Homesley, associate professor of obstetrics and gynecology, has been appointed president of the Forsyth County Unit of the American Cancer Society.

\* \* \*

Dr. Joseph E. Johnson III, professor and chairman of the Department of Medicine, has been appointed to the Federated Council for Internal Medicine. The council is composed of twelve members who represent the major groups of internal medicine in the United States.

\* \* \*

Dr. Richard C. Proctor, professor and chairman of the Department of Psychiatry, has been appointed to a three-year term on the Darlington School Advisory Board, Rome, Ga.

\* \* \*

Dr. M. Madison Slusher, associate professor of ophthalmology, has been re-elected to the editorial board of the Southern Medical Journal for the coming year.

\* \* \*

Dr. Walter A. Ward, assistant professor of otolaryngology, was elected president-elect of the American Society of Ophthalmology and Otolaryngologic Allergy Sept. 11 at the annual meeting in Las Vegas. He also was selected to represent the society at the American Council of Otolaryngology.

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## News Notes from the

### UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

A team of immunologists at the UNC-CH School of Medicine has received a \$150,000 grant from the American Cancer Society to continue research on type of cancer in mice.

The group, headed by Dr. Geoffrey Haughton, professor of bacteriology and immunology, is conducting research on a series of lymphomas, white blood cell tumors, discovered in laboratory mice. The lymphomas resemble several types of cancer in humans, including chronic lymphocytic leukemia, a common killer of adults in the United States, and Burkitt's lymphoma, which is less prevalent in this country but common among African children.

The research will center on a effort to boost the body's (mice) immune defense mechanisms against the tumors and to combine this with conventional drug treatment to cure the disease.

The two-year research grant follows a \$25,000 research development grant Haughton received from the society in March.

\* \* \*

Dr. Pierre Morell, professor of biochemistry and nutrition, has been named director of the university's curriculum in neurobiology.

Morell joined the University in 1973 as an associate professor and research scientist in the UNC-CH Biological Sciences Research Center of the Child Development Institute. He was named professor in 1977.

He also has taught at the Albert Einstein College of Medicine, where he earned his Ph.D. in 1968. He received his B.A. from Columbia College of Columbia University in 1963.

Morell currently serves on the neurology study section of the National Institutes of Health and is on the editorial boards of three journals.

\* \* \*

Dr. Thomas R. Griggs, assistant professor of medicine and pathology, has been named a Jefferson-Pilot Fellow in Academic Medicine. He will use his four-year fellowship to study the diagnosis and treatment of coronary patients.

A native of Lexington, Griggs received his M.D. from the UNC-CH School of Medicine and served his residency at Johns Hopkins. He returned to Chapel Hill in 1971 as a fellow in hematology in the department of pathology.

\* \* \*

Dr. Donal Dunphy, professor of pediatrics, has



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been named associate chief of staff for 1978-1979 at North Carolina Memorial Hospital.

He chaired the department of pediatrics at the University of Iowa before joining the medical school faculty here in 1973. He has served as the pediatric liaison for the N.C. Area Health Education Center program, is a former acting chairman of the medical school's department of family medicine and serves in an administrative capacity on numerous committees throughout the medical center.

\* \* \*

The neurosurgical library at UNC-CH has been dedicated in honor of Dr. Gordon S. Dugger, former chief of the division of neurosurgery and professor of surgery. Dugger, who recently retired after nearly 25 years with the School of Medicine and N.C. Memorial Hospital, is a native of Vilas. He received his A.B. in 1941 from UNC-CH and his M.D. in 1945 from Johns Hopkins School of Medicine.

\* \* \*

A master's degree program in occupational therapy, the only such program in the state, has been established in the department of medical allied health professions in the UNC-CH School of Medicine. The two-year program, which leads to a Master of Science degree, is designed for the student whose undergraduate degree is not in occupational therapy.

The first year of the program consists of basic classroom study. The second year includes a significant amount of observation and experience working with handicapped individuals.

\* \* \*

Dr. Michael Swift, associate professor of medicine and chief of the division of medical genetics in the department of medicine, has received a \$63,000 grant from the National Library of Medicine to write a book that reviews research on the genetic connection in cancer.

The book will be designed as a practical aid for clinicians in treating patients and to stimulate further research. It will include such topics as what to look for in "cancer families," what forms of cancer appear hereditary and how certain environmental agents may cause cancer in people who are genetically predisposed to the disease.

\* \* \*

Dr. Cecil G. Sheps, professor of social medicine, is co-editor of a book used as a background document at the World Conference on Primary Care in Alma Ata in the Soviet Union in September.

Two other UNC-CH faculty members, Dr. John W. Hatch, associate professor of health education in the School of Public Health, and Dr. Carolyn A. Williams, associate professor in the School of Nursing and assistant professor of epidemiology in the School of Public Health, contributed chapters to the book.

"Primary Health Care in Industrialized Nations,"

published by the New York Academy of Sciences, is the result of a 1977 conference held in New York by the academy and co-sponsored by the Sandoz Foundation, the United States Public Health Service and the World Health Organization.

\* \* \*

Debora Poole Shadburn has been named director of business affairs in the School of Nursing. She succeeds Marilyn Riddle, who has returned to the School of Medicine as director of business affairs in the department of medicine.

\* \* \*

Dr. William J. Yount, professor of medicine, is on Kenan leave of absence for a year to do research on basic immune regulatory mechanisms with Dr. G. I. Asherson, head of immunological medicine at the clinical research center in Harrow, England. He will try to discover why antibodies that normally defend against threats, such as harmful bacteria, sometimes become misdirected and damage the body's own tissues.

\* \* \*

Dr. A. Myron Johnson, associate professor of pediatrics and pathology, has been named associate director of the blood bank at North Carolina Memorial Hospital.

\* \* \*

Louis Turrentine, special procedure radiographer, is the 1978 recipient of the Doris S. Newton Award presented by the graduating class in radiologic science to a member of the clinical faculty for outstanding contribution to the students' clinical development.

\* \* \*

Dr. W. Bonner Guilford, assistant professor of radiology, was elected president of the Southeastern Society of Skeletal Radiology at its annual meeting in Hilton Head, S.C. Guilford presented "Soft Tissue Lesions of Unusual Etiology" during the scientific sessions.

\* \* \*

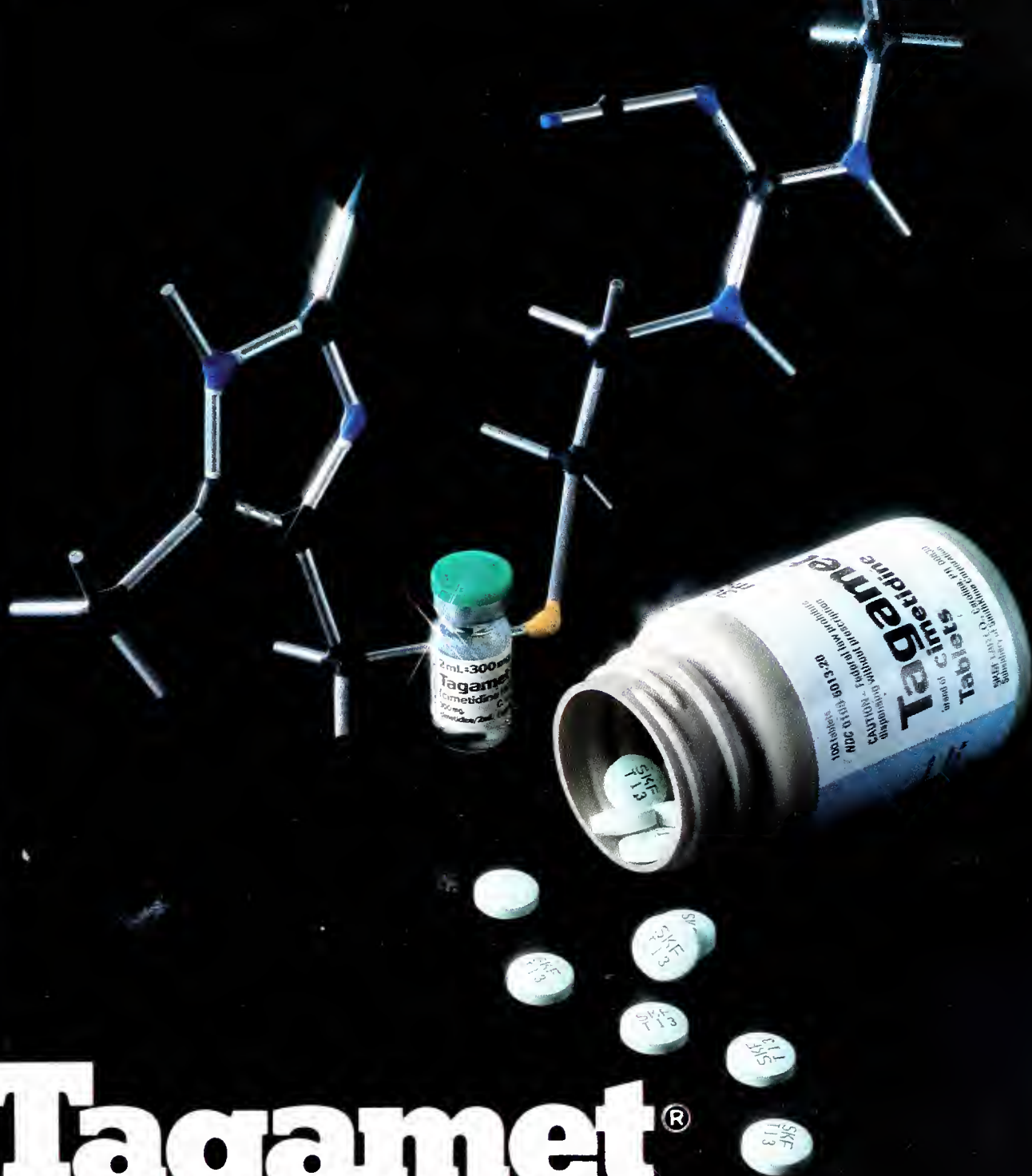
Dr. Frank C. Wilson, professor of surgery, presented "Low Back Pain and Injuries of the Shoulder" at the Seaboard Medical Society annual meeting in Nags Head and instructional course lectures on "Pathogenesis of Ankle Fractures" and "Management of Ankle Injuries" at the Summer Institute of the American Academy of Orthopaedic Surgeons in Boston.

Wilson was appointed by the directors of the American Academy of Orthopaedic Surgeons as alternate delegate to the fall meeting of the American Medical Association.

\* \* \*

Dr. Kenneth M. Brinkhous, professor of pathology





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in functional G.I. disorders\*

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\*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964

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# Bentyl (dicyclomine hydrochloride USP)

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## Brief Summary INDICATIONS

For use as adjunctive therapy in the treatment of peptic ulcer. IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGIC/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

**CONTRAINDICATIONS:** Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia; palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness; dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

**Usual Dosage:** Bentyl 10 mg capsule and syrup Adults 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children 1 capsule or teaspoonful syrup three or four times daily. Infants ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg Adults 1 tablet three or four times daily. Bentyl Injection Adults 2 ml (20 mg) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1976

was selected as a Wellcome Visiting Professor in the Basic Medical Sciences for the 1978-1979 academic year by the Burroughs Wellcome Fund and the Federation of American Societies for Experimental Biology. He is one of 18 selected this year.

As a Wellcome Visiting Professor, he will spend from two to five days teaching and talking with students and faculty at the University of South Florida. He will also deliver a Wellcome Lecture in the basic medical sciences. The program was developed to stimulate interest in the basic sciences and to recognize eminent scientists in the basic research disciplines.

\* \* \*

Dr. Dennis W. Ross, pathology, presented "A New Technique for Surveillance of Response to Chemotherapy in Acute Leukemia" at the International Congress of Hematology and Blood Banking Symposium in Paris.

\* \* \*

Dr. Eugene P. Orringer, assistant professor of medicine, presented "Ascorbic Acid Mediated Transmembrane Reducing System of the Human Erythrocyte" to the International Society of Hematology meeting in Paris.

\* \* \*

David Metz, associate director of the Area Health Education Center, presented "Building Linkages Necessary for Successful Health Care Delivery" at the annual meeting of the National Association of Community Health Centers in Louisville, Ky.

## News Notes from the—

### DUKE UNIVERSITY MEDICAL CENTER

The comprehensive cancer center has reached another milestone with the dedication of the newest building in the cancer complex, the Edwin A. Morris Clinical Cancer Research Building.

At dedication ceremonies in September, the guest speaker was Dr. Arthur Upton, director of the National Cancer Institute which granted \$4.24 million for the facility.

Another \$1 million toward the building's construction came from the man for whom it was named, Edwin A. Morris of Greensboro, chairman of the board of Blue Bell, Inc., and 22 other groups and individuals made contributions of \$10,000 or more each.

The building contains outpatient treatment facilities and the 20-bed inpatient B. Everett Jordan Ward named for the late U.S. senator from North Carolina himself a cancer victim.

In a review by the National Cancer Advisory Board earlier this year, the Duke cancer center was ranked

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number one among the 19 comprehensive cancer centers in the country.

\* \* \*

Dr. Lawrence Myers, assistant professor of community and family medicine, presented a paper entitled "A Markov Chain Model for Prostate Cancer" at the annual meeting of the American Statistical Association in San Diego. Co-authors were Drs. David J. Paulson, William Berry, Edwin B. Cox, John Laszlo and Wilma Stanley.

\* \* \*

Dr. Daniel B. Menzel, associate professor of pharmacology and medicine, was one of six scientists from the Research Triangle area who recently served on an Environmental Protection Agency panel studying nitrogen oxide. Their advice will be used in formulating national air pollution control standards.

\* \* \*

The Damon Runyon-Walter Winchell Cancer Fund of New York City has awarded a post-doctoral fellowship to a Duke scientist involved in enzyme research. The recipient of the \$15,000 grant is Dr. Kenneth J. Dean, who is seeking to purify and characterize a

protein enzyme called alpha galactosyltransferase which is used in synthesizing glycolipids, a type of fat, on the surface of cells.

"Characterization of the enzyme," Dean said, "will make it possible to see if changes occur in the enzyme when a cell is cancerous and further to establish if there is any relationship between these changes and cancer."

\* \* \*

Dr. Andrew Wallace, chief of cardiology, addressed an international seminar on "Fitness Training for Adults" at the Life Planning Center in Tokyo in September. He described the Duke University Preventive Approach to Cardiology (DUPAC) program.

Wallace also was a visiting professor at four Japanese medical schools before returning to Tokyo later in the month to address the World Congress of Cardiology on the role of computers in management decisions related to chronic illnesses.

\* \* \*

Thirty-two of this year's entering class of 114 in the School of Medicine are from North Carolina.

Altogether, 53 undergraduate schools are represented by the men and women in the first-year class.

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and 31 are Duke graduates. The students, who are from 30 states, were chosen from nearly 4,000 applicants.

North Carolina students are:

Christine Graham Bounous, Susan D. James, James S. Mitchner III, B. Dale Russell and Patrick Vogel from Durham; Donna Grey Anderson of Lumberton; Graham A. Barden III and Edwin L. Bell of New Bern; Timothy M. Browder, Thomas H. Grote, James D. Lingle III and Samuel G. Weir III of Charlotte; Paul C. Browne of Winston-Salem; William R. Burge of Farmville.

William D. Caffrey Jr. of Greensboro; Elizabeth E. Campbell and Terrence S. Early of Chapel Hill; William G. Cance of Asheville; Georgette Dent, Samuel T. Dove, Hilary K. Ellwood, Susan C. Page and Wilburn J. Smith III of Raleigh; Michael G. Glover of Wilson; Charles S. Haworth of High Point; Kemp H. Kernstine of Fayetteville; Grace McCall of Marion; Raymond A. Shelton of Burlington; Arthur V. Stringer of Concord; Jeffrey S. Warren of Salisbury and William W. Woodruff III of Lexington.

\* \* \*

Three medical center faculty members have been appointed to administrative posts with the School of Medicine.

Dr. Arthur C. Christakos, professor of obstetrics and gynecology, has been named associate dean of graduate medical education. He succeeds Dr. William D. Bradford in the position.

Dr. Delford L. Stickel, professor of surgery and associate medical director of Duke Hospital, succeeds Dr. John L. Weinerth as director of postgraduate medical education.

The new position of associate dean for allied health and administration has been filled by Dr. Thomas T. Thompson, associate professor in the departments of radiology and community and family medicine. Thompson already had responsibilities for allied health education and will continue in the role.

\* \* \*

Other faculty promotions and appointments include:

Drs. Lowell A. Goldsmith, James J. Morris Jr. and Sheldon R. Pinnell to professors of medicine; Dr. Melvyn Lieberman to professor of physiology; Drs. David M. Hawkins and John J. Sullivan to associate professors of psychiatry; Dr. Robert M. Bell to associate professor of biochemistry.

Dr. Erwin M. Thompson appointed assistant professor of psychiatry; Drs. Earl A. Surwit, Joseph M. Miller Jr. and L. Joseph Swaim, assistant professors of obstetrics-gynecology; and Dr. Robert I. Fishburn, assistant professor of radiology.

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Each capsule contains 5 mg  
chlordiazepoxide HCl and 2.5 mg clidinium Br.

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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\*Librax has been evaluated as possibly effective for this indication.  
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## Month In Washington

The AMA has told Congress strict enforcement of the law should apply to the small number of physicians who prescribe psychotropic drugs solely for profit. At the same time, the lawmakers were cautioned not to take action that would restrict the physicians' armamentarium "in order to correct the abuses of a few."

Joseph F. Boyle, M.D., a member of the AMA Board of Trustees, told the House Select Committee on Narcotics Abuse and Control that "when poor prescribing practices are a problem, we believe corrective measures can be taken through information distribution and continuing medical education." Dr. Boyle said, "It cannot be emphasized enough that statistics regarding the amount of a drug prescribed or the number of prescriptions written cannot be used to document so-called misprescribing of drugs in medical practice."

There are no adequate data, for instance, on how

many people suffer from severe anxiety symptoms, Dr. Boyle noted. Increased access to care through federal medical programs, community treatment of mental illness, greater awareness of the need to seek medical help for mental conditions — all could play a role in higher than expected use of psychotropic drugs, he pointed out.

It is undeniable that there are certain problems in the prescribing of certain psychotropic drugs, Dr. Boyle testified. "These problems include any blatant misuse of the trust granted to physicians by a small group of physicians who prescribe these drugs solely for profit. When it can be established that a physician or other prescriber is prescribing or dispensing drugs for non-medical uses, appropriate actions should be taken to halt such activity. We support strict enforcement of the law."

The AMA has developed model state legislation providing for disciplinary actions against physicians

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found guilty of specified infractions, including "unprofessional conduct." Most state Medical Practice Acts include within the definition of unprofessional conduct the prescribing and/or administering of certain types of drugs in a non-therapeutic or unprofessional manner, Dr. Boyle noted.

He said the AMA "supports efforts designed to eliminate improper prescribing, and we believe the principal means for achieving such a result is to provide unbiased, valid and current information to physicians on the risks and benefits of particular drugs in various treatment situations." However, "we caution against any federal action that could, in effect, reduce the availability of patient treatment by restricting the physician's armamentarium to treat illness and injury in order to correct the abuses of a few."

The second AMA witness was Daniel X. Freedman, M.D., Chairman and Professor of Psychiatry at the University of Chicago and chief editor of the Archives of General Psychiatry of the AMA who said that "although the benzodiazepines do have a potential for abuse and dependence differing from that of antipsychotic and antidepressant drugs, their relative safety in terms of therapeutic doses and toxic effects provides an advantage over the barbiturates."

The number of prescriptions for all benzodiazepines

has plateaued while prescriptions for barbiturates and related drugs have decreased, he noted. The benzodiazepines have actions other than anti-insomnia and anti-anxiety, which accounts for their use in selective amnesia and intravenous anesthesia, spasticity, local skeletal muscle spasm, certain dyskinesias, and treatment of seizures, he noted.

"Moreover, a substantial percentage of the prescriptions for benzodiazepines are not for a primary complaint of anxiety or insomnia but for these conditions in conjunction with episodes of other illnesses."

"The wider use of these drugs by women is a transnational trend and may in part be explained by their greater utilization of the health care system and their willingness to seek help sooner than men for all primary care problems," said Dr. Freedman, "although their changing role in society which likely heightens anxiety may also be a contributing factor."

\* \* \*

The first top-level health official of the Carter Administration to topple is Robert Derzon, ousted as head of the stripling Health Care Financing Administration (HCFA), the new agency that operates Medicare and Medicaid.

Derzon fell out with HEW Secretary Califano in

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disputes over policy and over organizational matters. Derzon wasn't moving fast enough to whip HCFA into shape, Califano believed. Derzon, 47, a hospital administrator, took issue with the belligerent attitude of Califano toward health providers.

Califano has been under pressure from Congress to get HCFA moving. The agency was originally the idea of the Senate Finance Committee and was embodied in proposed legislation. Califano preempted the plan and made the sweeping organizational shift 18 months ago. Medicare had been under social security; Medicaid under HEW's welfare division.

Derzon was a soft-spoken official who never quarreled with his boss in public. He had been administrator of the University of California-San Francisco hospitals and clinics. Named to succeed him was Leonard D. Schaeffer, currently assistant HEW secretary for management and budget. Schaeffer, 33, was director of the Bureau of the Budget of the State of Illinois for 18 months, beginning in 1975, and Deputy Director for Management of the Illinois Department of Mental Health and Developmental Disabilities for the two preceding years. Before joining HEW nine months ago, he had served as a vice president for financial and business planning at Citibank in New York.

\* \* \*

Twenty-seven Blue Cross and Blue Shield plans will

reimburse for second opinions on the need for elective surgery recommended by physicians. "Many more plans" are expected to be involved in second opinion surgery programs in the near future, Blue Cross-Blue Shield reported.

Under the program, all charges related to the second opinion, including the consulting specialist's fees, x-rays and laboratory tests, are covered by the plans. If the second opinion differs from the first, some plans pay for a third opinion to help the subscriber decide whether or not to have surgery.

Walter J. McNerney, president of the Blue Cross and Blue Shield Associations, said a major purpose of the pre-surgical consultation programs is to determine the extent to which an additional independent opinion results in significant savings or in improvement of patient care by reducing the incidence of elective surgery.

The Blues released the statement on second opinions to coincide with the scheduled official launching of HEW's second opinion program for Medicare and Medicaid. The government plans an extensive publicity campaign to encourage the public to seek second opinions when suitable.

In comment upon the HEW program James H. Sammons, M.D., AMA Executive Vice President, commented: "The concept of second opinions is not new to the medical profession. The AMA has for years supported voluntary consultation. The association's

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Principles of Medical Ethics specifically state that, 'a physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.'

"The Department of HEW claims that its national second opinion program will be cost reducing. However, such a program promises to increase utilization of physician services as Medicare and Medicaid patients across the country are urged to seek a second opinion before all non-emergency surgery. Short-term results of several experimental second opinion programs have not provided clear evidence that a national program of this type will either improve the quality of care or reduce health costs."

\* \* \*

New financial disclosure rules have been proposed for providers under Medicaid, Medicare and the Maternal and Child Health Program.

The rules require private institutions, organizations, and agencies providing health-related services to beneficiaries of these programs to disclose ownership and other business-related information.

"These rules would give us an important new tool with which to ferret out evidence of fraud and abuse in those important programs and prosecute offenders," HEW Secretary Califano said.

"They will help us identify situations in which self-dealing, interlocking directorates, or other arrangements allow providers to make excessive profits. In addition, the existence of this requirement will serve as a deterrent to those who would use obscure business arrangements to defraud the taxpayers," he said.

Three major new requirements were proposed. Any organization providing services must disclose to HEW the identity of persons with certain ownership or controlling interests in the organization, or in a subcontractor. These organizations, except for those which deal exclusively with the Maternal and Child Health Program, must also disclose information on certain business transactions.

\* \* \*

A new disease classification system for use in hospitals and related clinical settings has been endorsed by HEW. Starting next year, the system will be required in HEW-financed programs such as Medicare, the Professional Standards Review Organization program and the Cooperative Health Statistics System.

The new system, called the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), will be used to coordinate statistics on health problems and health care in hospitals and similar institutional environments. The statistical reports and analyses produced will be used for many purposes including quality assurance, health planning and research.

ICD-9-CM contains over 10,000 five-digit diagnostic codes and more than 3,000 four-digit medical procedure codes. HEW said the system is compatible

## BRIEF SUMMARY OF PRESCRIBING INFORMATION

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### ORAL SUSPENSION

**Actions.** Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

**Indications.** For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

**Warnings.** *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

**Precautions:** Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

**Adverse Reactions.** The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

**Dosage and Administration.** *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

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ORAL SUSPENSION



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pinworm infections

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with the existing international classification of diseases, ninth revision, produced by the World Health Organization, and provides a significant improvement over the classification systems now in use in the United States.

Currently, the two major disease classification systems being used throughout the nation are the ICDA-8 and HICDA-2 systems. According to HEW officials, the use of these competing classification systems has made standardization of statistics difficult to accomplish. HEW officials said the universal adoption of the ICD-9-CM as a simple system would eliminate these problems and that its use would represent a major technical advance in recording health statistics.

HEW has entered into a contract with the Commission on Professional and Hospital Activities (CPHA) to produce adjunct materials necessary for the implementation of this system.

\* \* \*

A federal draft guide of pharmacy prescription drug prices intended for physicians has been labeled "extremely misleading" by the Pharmaceutical Manufacturers Association (PMA).

"Truly relevant data could be a useful adjunct to existing information sources, but we do not believe that this particular model meets their standard," PMA President C. Joseph Stetler said in a letter to the HEW Department.

The PMA said the price book could cause confusion "as pharmacists undertake to make prescribers and consumers understand why their prescriptions do not cost what this book seems to say they should."

HEW used pharmacy acquisition cost data as a base "even though average retail treatment cost information would be less misleading and is readily available," said Stetler.

"Those data . . . exaggerate the differentials to be found in the actual prescription market, whether between the average prices and treatment of different drugs or of different versions of the same drug," he said. And — "manufacturers often provide pharmacists with labor reducing unit-of-use packaging, special purchasing discounts, and services such as a re-

turn goods policy allowing inventory reductions and comprehensive product liability coverage — all of which reduce costs."

PMA compared examples of price ratios from the HEW Guide to Average Retail Price Ratios for Typical Prescriptions which it said "clearly showed that the book's price differences were exaggerated."

\* \* \*

The Food and Drug Administration will require that most drugs be labeled to specify the date after which they should not be used.

FDA Commissioner Donald Kennedy said the expiration dating requirement — which will cover all prescription drugs and most non-prescription drugs — should "provide a new protection for consumers, who will have further assurances that the drugs they purchase retain their quality."

Under the old rules, expiration dates were required only for drugs which were "liable to deterioration" such as antibiotics.

\* \* \*

New drugs and medical devices developed with federal aid are "wasting away on the shelves of bureaucrats" due to government patent policies, a group of senators has charged.

Sens. Robert Dole (R-Kan.) and Birch Bayh (D-Ind.) have introduced legislation to encourage the government to allow universities, non-profit organizations and small businesses limited patent protection to market discoveries they have made under federal auspices. The patent holder would reimburse the government out of royalties and income for federal research expenditures.

Joining Dole and Bayh were Sens. Charles Mathias (R-Md.), Dennis Deconcini (D-Ariz.) and Orrin Hatch (R-Utah).

Dole said that "the present government policy mandates the government take title to all inventions it has had a hand in funding. The policy discourages participation by the private sector, with the end result being such that the innovation will never be brought to the marketplace for use by the public."

# In Memoriam

## **RICHARD BENJAMIN BOREN, III, M.D.**

During the night of April 10-11, Richard Benjamin Boren, III, died in his sleep, shortly before his 49th birthday. Though he was apparently in good health, we now know that he had not been without cardiac warnings which he did not share with anyone.

Dick Boren was a man with almost boundless energy. At times his enthusiasm was misunderstood as mere flamboyance by those who did not know him well and who overlooked that his drive was always directed toward specific goals and was sustained until the task was completed.

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**Contraindications:** Tablets in children under 6 months of age, known hypersensitivity, acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**ORAL:** Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients, should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication, abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

**INJECTABLE:** To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less), prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

**Precautions:** If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function, avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

**INJECTABLE:** Although promptly controlled, seizures may return, readminister if necessary. Not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

**Adverse Reactions:** Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

**INJECTABLE:** Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm, pain in throat or chest have been reported.

**Management of Overdosage:** Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

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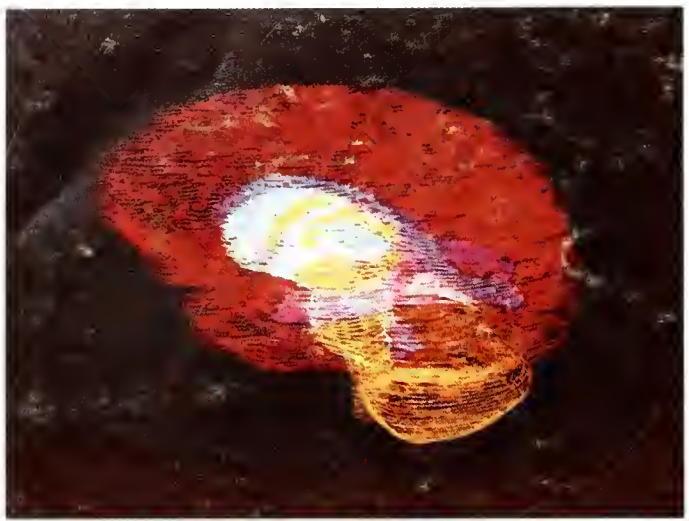
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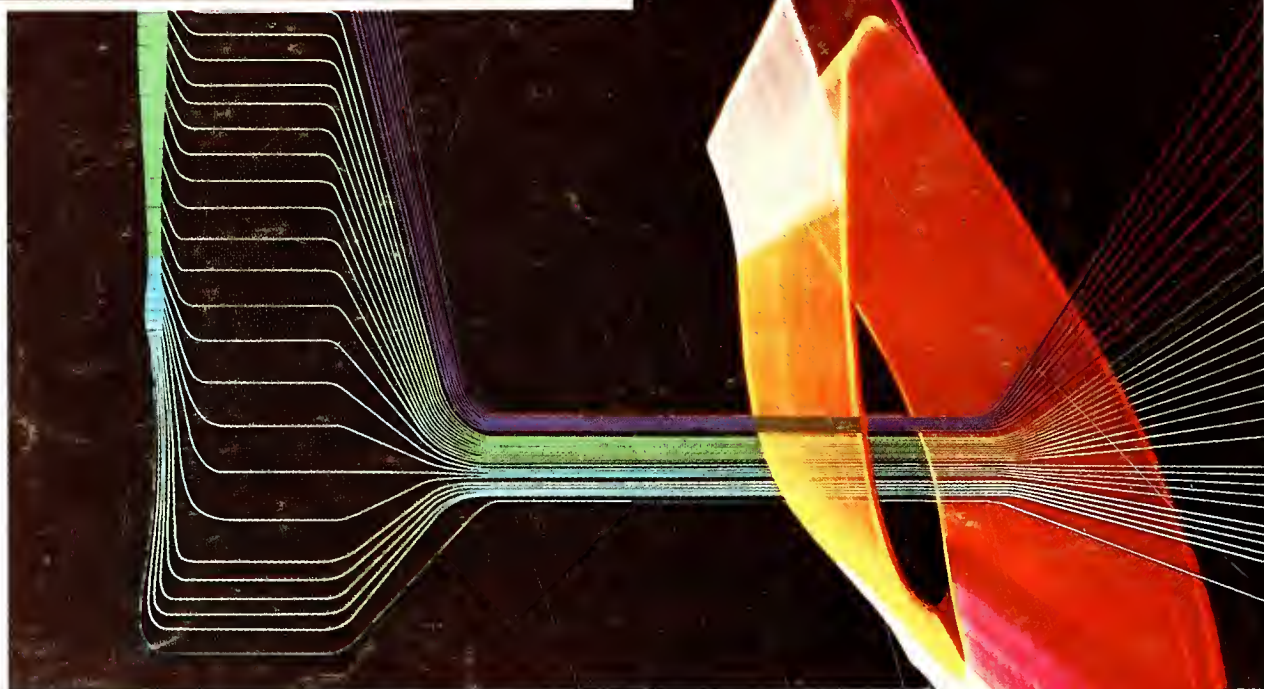
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The Official Journal of the NORTH CAROLINA MEDICAL SOCIETY □ □ □ December 1978, Vol. 39, No. 12

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**CURRENT CONCEPTS: The Treatment of the Lymphomas:** M. Robert Cooper, M.D., Hyman B. Muss, M.D., Frederick Richards, II, M.D., John J. Stuart, M.D., Douglas R. White, M.D., and Charles L. Spurr, M.D.

**Clinical Experience with Copeland Iris Plane Intraocular Lens Implantation:** Martin J. Kreshon, M.D., and John A. Young, M.D.

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. Abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Use in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation.

**Side Effects:** Drowsiness, confusion, diplopia.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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December 1978, Vol. 39, No. 12

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- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

\*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective

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- 2 In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease

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Vasodilan injection, isoxsuprine HCl, 5 mg., per ml

**Dosage and Administration:** Oral 10 to 20 mg., three or four times daily.  
Intramuscular 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.  
Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed.

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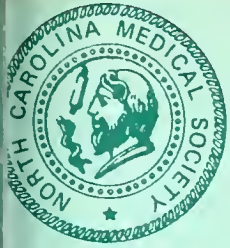
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# PRESIDENT'S NEWSLETTER

NORTH CAROLINA MEDICAL SOCIETY

No. 7

December 1978

Members of the Medical Society purchased and have donated a World War II Army Medical Railroad Car to the N. C. Department of Cultural Resources to be included in the Transportation Museum at the Historic Spencer Shops. I would like to thank each one of you who contributed to this special project, and I believe that it will be a worthwhile addition to the Museum.

James H. Sammons, M.D., Executive Vice-President, AMA, stated this month in a letter to the Society: "I am pleased to inform you that the North Carolina Medical Society has exceeded its year end 1977 dues paying AMA membership. Congratulations to you and the Society Staff who have helped to achieve these important membership gains. It clearly demonstrates that North Carolina physicians recognize the vital role being performed by the AMA. Yours is one of 32 state medical associations that already has strengthened its AMA membership this year." We are each proud of our AMA membership and believe that through the strong efforts of organized medicine, we can preserve and enhance our profession in the years to come. At the present time we have approximately 7,400 physicians in North Carolina, 5,385 members of the North Carolina Medical Society, and of this number 4,279 are AMA members. We need to increase our AMA membership in 1979.

**Myth:** There is a shortage of doctors in America because the AMA practices "professional birth control" to keep physicians' services in demand.

**Reality:** At the end of 1977 there were 414,443 physicians in the U. S., a gain of 80,415 since 1970. Currently 122 U. S. medical schools are graduating 15,000 physicians a year--nearly double the number graduated a decade ago. The AMA has supported this dramatic increase in physician supply. The U. S. now has one of the world's highest ratios of physicians to population, and for many years the number of physicians has been increasing three times faster than our population. There are still maldistribution problems to consider. More physicians are needed in inner cities, rural areas and in the primary care disciplines.

Many of you have been quite interested in the matter of second surgical opinion and here are the latest figures as of November 1978.

The Prudential Insurance Company, as carrier for Medicare in North Carolina and in compliance with HEW regulations, stated they had signed 975 doctors for the second surgical opinion panel but had received only 19 requests for such second opinions under Medicare. Meanwhile, North Carolina Blue Cross & Blue Shield stated that approximately 1,600 physicians have agreed to serve as a consult panelist to provide pre-surgical examinations for their subscribers who are entitled to benefit coverage for such service. Presently, this is applicable only to the 10,000 Southern Bell employees in North Carolina, and NO requests for second surgical opinions have been received. The Executive Council on October 1, 1978, passed a motion to recommend to the membership not to place their names on any closed or open panel list for second surgical opinions.

John Glasson, M.D., Durham, is Vice-Chairman of the Council on Medical Service of AMA and will be a candidate for re-election to this Council at the AMA meeting in Chicago in July 1979.

Here are items of interest from the last Executive Council meeting:

The Executive Council approved a recommendation from the Council on Review and Development that the Committee on Legislation and the Committee on Communications be established as free-standing committees and that the Chairman of the Committee on Communications be made an ex officio member of the Executive Council, without vote. (The Chairman of the Committee on Legislation is already an ex officio member of the Executive Council without vote.)

The Council passed a motion that a Committee on Ethics and Religion be appointed by the President.

John S. Rhodes, M.D., Raleigh, Associate Editor, North Carolina Medical Journal, reported for the Editorial Board that in the future a notice will be sent to each Life Member of the Society allowing him the privilege of requesting that he continue to receive the Journal or not to receive it.

The Executive Council reaffirmed its support of the North Carolina Medical Society's policy on continuing medical education. At this date there are 4,281 members of our Society who should have reported their Continuing Medical Education requirements for the first three-year period. Of this number 3,750 have completed their requirements and as yet we have 531 doctors who must report these by December 31, 1978, or they will not be eligible for membership in the Society in 1979. I encourage each of you who have not reported your CME requirements to, please, do so immediately. I feel that many physicians have met these requirements but have not taken the time to report them.

The Council adopted a resolution that initial certification or recertification by a specialty board is sufficient documentation of completion of continuing medical education requirements (in the Society) for a three-year period.

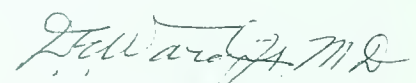
Josephine Newell, M.D., Bailey, Chairman of the Annual Convention Commission, stated that a new format has been adopted for the Annual Meeting in May 1979. The meeting will be compacted into three days--Thursday, Friday, and Saturday--which will leave Sunday morning available for specialty meetings. There will not be a MEDPAC Dinner at the Annual Meeting, and I hope that each of our medical schools will utilize Friday night for Alumni activities and dinners.

The Council approved the Bylaws Committee recommendation to be submitted in the 1979 House of Delegates in accordance with an action of the 1978 House changing the requirement for submitting resolutions for the Annual Meeting from 30 to 60 days prior to the first meeting of the House.

On the recommendation from the Committee on Child Health, the Council voted to retain the syphilis testing requirements of G.S. 51-9 (marriage license) but to endorse abolishment of the rubella testing by the 1979 General Assembly.

Your Society officers would like to extend Seasons Greetings to each of you, and we sincerely wish that your holidays be filled with family fellowship, love, and good health. May the Lord live in your heart this Christmas and during the New Year.

Sincerely,



D. E. Ward, Jr., M.D.  
President



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# The Treatment of the Lymphomas

M. Robert Cooper, M.D., Hyman B. Muss, M.D.,  
Frederick Richards, II, M.D., John J. Stuart, M.D.,  
Douglas R. White, M.D., and Charles L. Spurr, M.D.

## THE LYMPHOMAS

LYMPHOMAS account for 21,900 cases of malignancy and over 12,000 deaths yearly with Hodgkin's disease responsible for 3,400 new cases and 4,300 deaths annually. Although the lymphomas represent a small portion of the total problem, the results of treatment are dramatic and provide a model for the development of improved therapeutic programs for other neoplastic diseases.

## HODGKIN'S DISEASE

Patients with Hodgkin's disease have shown continuing improvement in survival. An early study<sup>1</sup> of single drug therapy showed complete remission in 18% of patients with advanced Hodgkin's disease who had received no prior treatment. Fewer than 10% of patients with advanced disease then survived five years when treated either with radiation therapy or a single drug. Today, approximately 70% of patients treated for Hodgkin's disease can be assured a normal life expectancy. Early stages of the disease (those limited to a nodal area of

the body) can be treated effectively with radiation. More advanced disease, Stage III and Stage IV, can be effectively managed with combination chemotherapy (Table I).

A precise diagnosis is fundamental in the management of Hodgkin's disease. Histological classification is important for the identification of clinical patterns and for prognosis. We recognize four histological varieties: lymphocyte predominance, nodular sclerosing, mixed cellularity, and lymphocyte depletion. These types can be correlated with the clinical findings and subsequent course of the disease. Nodular sclerosing Hodgkin's disease is more common in females, is frequently characterized by a mediastinal mass and has a high incidence of splenic involvement. Ninety-four patients reviewed at the Bowman Gray School of Medicine showed the median survival of the lymphocyte depletion group to be 19.6 months, nodular sclerosing 78.7 months and mixed cellularity 94 months. Patients with lymphocyte predominance disease have not yet reached their median survival, which is approaching 98 months.

Accurate staging is extremely important in determining treatment. Early Hodgkin's disease is gener-

ally unifocal and spreads from one lymph node area to another by contiguous lymphatics. Table I describes a useful and simple clinical classification.

In addition to clinical staging, pathological classification has contributed to our understanding of Hodgkin's disease and subsequent improvement in therapy. A good history, physical examination, roentgenographic studies, lymphangiography and sonic scanning can still result in inaccurate staging in some individuals. The role of diagnostic laparotomy has been evaluated<sup>2</sup> in 309 patients. When the lymphangiogram was positive, at least 75% of patients had disease in the abdomen. Of 184 patients with negative lymphangiograms, 45% were found to have intra-abdominal disease, most often involving the lymph nodes or spleen. Approximately one-third of patients will have splenic involvement undetected by non-invasive techniques.

Surgical staging with splenectomy, liver wedge biopsy and node sampling should be performed only in good risk patients when therapy may be directly affected by the findings at laparotomy. Splenectomy does prevent hypersplenism due to organ involvement by lym-

From the Department of Medicine  
Section of Hematology/Oncology  
Bowman Gray School of Medicine  
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Reprint requests to Dr. Cooper

TABLE I: HODGKIN'S DISEASE

Clinical Staging		Treatment
Stage I	Disease limited to one anatomic or two contiguous anatomical regions on the same side of the diaphragm	Irradiation therapy (extended field, mantle therapy)
	A No symptoms of systemic disease B With symptoms of systemic disease	
Stage II	Disease in two anatomical or more than two contiguous anatomical regions on the same side of the diaphragm	Irradiation therapy (extended field, mantle therapy) Total nodal irradiation therapy by the 3-2 technique followed by 6 mos. of combination chemotherapy
	A No symptoms of systemic disease — B With symptoms of systemic disease —	
Stage III	Disease on both sides of the diaphragm but limited to lymph nodes, spleen, and/or Waldeyer's ring	Total nodal irradiation therapy by the 3-2 technique followed by 6 mos. of combination chemotherapy Combination chemotherapy for at least 6 mos. followed by careful restaging and/or maintenance chemotherapy
	A No symptoms of systemic disease — B With symptoms of systemic disease —	
Stage IV	Disease in area other than lymph nodes extranodal disease, lung, central nervous system, liver, skin, gastrointestinal tract, genitourinary tract, bone marrow	Combination chemotherapy for at least 6 mos. followed by careful restaging and/or maintenance chemotherapy
	A No symptoms of systemic disease B With symptoms of systemic disease	

phoma. It also decreases the amount of radiation necessary for effective treatment. In premenopausal females, an oophoropexy is routinely performed at our institution to move the ovaries laterally from the major radiation field. Although others have reported a high morbidity with staging laparotomy,<sup>3</sup> we have found it quite safe and encountered few complications.

Total lymph node radiation delivered with megavoltage equipment has resulted in dramatic improvement in survival and perhaps some cures in patients with Stage I, II and III disease. Radiation therapy for patients with Stage I or II disease without symptoms results in 80% of patients being free of disease at five years with 70%-80% remaining free for 10 years.<sup>4</sup> However, patients with systemic symptoms (Stage B disease) have a failure rate after radiation therapy of between 25% and 60% within five years. These studies suggest that chemotherapy is important for patients with Stage III Hodgkin's disease (symptomatic or asymptomatic). Moreover, the recurrence in the site of previous bulky disease (mediastinal mass greater than one-third of the largest transverse diameter of the chest) is common. Our general recommendations for therapy are reflected in Table I.

Rappaport et al<sup>5</sup> reported that patients survived about 24 months after initial chemotherapy with single agents. In addition to the short duration of remission and survival, only 10%-30% of patients treated with single agents achieved complete remission. However, in 1970, DeVita et al<sup>6</sup> demonstrated that a four-drug program (MOPP — nitrogen mustard, vincristine, prednisone, and procarbazine) improved remission induction and prolonged the relapse-free interval. Thirty-six of 44 patients (81%) with Stage III and IV disease went into complete remission with 6-11 monthly cycles of MOPP therapy. The median duration of remission from the cessation of all therapy was 29-42 months with relapse in 12 of 31 patients when this study was reported. Subsequent randomized studies have shown a complete remission frequency with MOPP of 48%-69%.<sup>7-9</sup> Both remission frequency and duration of favorable response with the MOPP program have been superior to any single drug or combination used earlier.

Although MOPP therapy has been very effective, it is associated with significant toxicity, nausea, vomiting and neurological sequelae and patient compliance is difficult to obtain. A number of other drug combinations have been used to treat Stage III and IV Hodgkin's

disease and have been found equally effective. Bonadonna et al<sup>10</sup> administered adriamycin, nitrogen mustard, bleomycin, oncovin and prednisone and observed complete remission in 69% of patients in the initial induction regimen. A subsequent randomized study from this group<sup>11</sup> compared MOPP and ABVD (adriamycin, bleomycin, vinblastine and dimethyltrienolone imidazole carboxamide) and showed that after six cycles, MOPP produced complete remission in 69% and ABVD produced complete remission in 70% with comparable toxicity.

A recent prospective randomized study (565 patients) showed that 57% of patients treated with MOPP achieved complete remission compared to 69% of those given CVPP (CCNU, vinblastine, procarbazine and prednisone).<sup>12</sup> A highly significant difference favoring CVPP. The use of the nitrosourea drug, CCNU was identified as the factor promoting this difference. The comparison of remission duration for complete responders demonstrated a significant prolongation for patients receiving CCNU compared to those receiving nitrogen mustard during induction, regardless of the vinca alkaloid or the maintenance program employed after induction. An additional comparison of remission duration for those complete responders randomized to vinblastine alone during maintenance again demonstrated a significant advantage of CCNU over nitrogen mustard in the induction combination. Duration of remission was also evaluated for those patients who achieved a complete remission during induction and received periodic reinforcement with the induction program with the nitrosourea group again responding more favorably. Currently, 70.5% of the complete responders inducted with CVPP remain in remission after 56 months compared to 56.5% in remission 44 months after induction with MOPP. Both neurotoxicity and gastrointestinal toxicity were less with CVPP while hematopoietic toxicity was similar between the two groups.



An effective combination for patients with advanced Hodgkin's disease who are at risk of hematopoietic toxicity (over 60 and/or previous radiation therapy and chemotherapy) has been cyclophosphamide, vinblastine, procarbazine and prednisone: cyclophosphamide at a dosage of 500 mg/M<sup>2</sup> and vinblastine, 5 mg/M<sup>2</sup> on day 1 and 8 of each 28 day cycle, procarbazine given orally at a dosage of 100 mg/M<sup>2</sup> day 1 through 14, and prednisone, 60 mg/M<sup>2</sup> day 1 through 14. Therapy is cycled similarly to MOPP with intravenous medication being given day 1 and 8 of each 28-day cycle. Prednisone is given only with every first and third cycle as in the MOPP program. Patients more than 70 years old are given vinblastine and cyclophosphamide.

Patients with advanced disease who show evidence of progression after chemotherapy may respond to their initial induction program. In addition, patients resistant to their previous four-drug programs may be treated successfully with the following drugs.

- 1) Bleomycin, 4 mg/M<sup>2</sup> days 2 and 5
- 2) Dacarbazine (DTIC), 150 mg/M<sup>2</sup> days 1 and 5
- 3) Vincristine, 1.5 mg/M<sup>2</sup> day 1 and 5
- 4) Prednisone, 50 mg/M<sup>2</sup> days 1 through 6
- 5) Adriamycin, 60 mg/M<sup>2</sup> on day 1

This cycle may be repeated every three weeks. Patients with extensive liver disease or prior toxicity from radiation or chemotherapy should be started at half doses. The combination of adriamycin, bleomycin, velban and DTIC is equally effective.

Although maintenance therapy is controversial, some experimental evidence suggests that late intensification (pulse doses of the combination induction program) may be more effective than low-dose, continuous maintenance therapy. A randomized study is necessary to determine whether no maintenance, late intensification during maintenance, or low-dose, continuous therapy is the proper approach to the patient with advanced disease.

The increased frequency of second malignancies now associated with intensive radiation therapy and chemotherapy in patients with Hodgkin's disease makes this study mandatory.

The goal of therapy for early disease must be cure and for advanced disease, complete remission. Partial remissions are of short duration and are associated with significantly short survival. The reassessment of patients who have completed induction chemotherapy is essential. It is important to document accurately that all areas of involvement at the time of initial staging have returned to normal. It is now obvious that several chemotherapy programs are available with a high frequency of complete remission and a prolonged remission duration. These studies must now be carefully evaluated in regard to patient compliance, effect on gonadal function and the frequency of second malignancies.

### THE NON-HODGKIN'S LYMPHOMAS

In contrast to the excellent control of Hodgkin's disease, patients with non-Hodgkin's lymphomas have shown little improvement in overall survival since 1965. However, it has now been conclusively shown that individuals with the nodular varieties of non-Hodgkin's lymphomas have a median survival in the range of 7 to 8 years, regardless of the therapeutic program while diffuse types have a survival of 1 to 2 years. The Rappaport classification<sup>13</sup> is the most widely used pathological method of identifying these tumors. Table II compares the prognoses of the histological types of non-Hodgkin's lymphomas classified by this schema. The nodular varieties are grouped in the favorable prognostic group and the diffuse

varieties in the unfavorable category.

The relevance of cellular immunological markers in the non-Hodgkin's lymphomas is being explored. A recent study<sup>14</sup> has compared the Rappaport classification with the presence of B, T, or null cell surface markers. Ninety-seven percent of the nodular lymphomas were of the B cell type. The diffuse varieties were composed predominantly of the B cell group although many null and T cell types were also noted. The diffuse lymphomas with B cell markers survived significantly longer than those with null cells. However, it is difficult to show a significant difference within the diffuse lymphomas between those with B or T cell markers. It was concluded that survival was best predicted when both the histological type and surface marker data were combined.

The role of staging laparotomy is less well-defined in the non-Hodgkin's lymphomas. The majority of patients with nodular lymphomas have disseminated disease at diagnosis but tend to follow a more indolent course than those with diffuse lymphomas who may appear to have localized disease. Radiation therapy does not have as definitive role in this diverse group of diseases as in Hodgkin's disease. Thus, a staging laparotomy should be performed selectively and, in rare instances, when other procedures have failed to provide adequate information.

Radiation therapy is effective for the management of localized disease such as large retroperitoneal masses. However, the addition of radiation to chemotherapy does not appear to improve the remission rate or patient survival. Rigorous staging will place most patients with nodular lymphoma in the advanced categories of disease (Stage III or

**TABLE II: RAPPAPORT CLASSIFICATION OF THE NON-HODGKIN'S LYMPHOMAS GROUPED ACCORDING TO PROGNOSIS**

Favorable Category	Unfavorable Category
1) Nodular well-differentiated lymphocytic	1) Diffuse well-undifferentiated lymphocytic
2) Nodular mixed histiocytic and lymphocytic	2) Diffuse mixed histiocytic and lymphocytic
3) Nodular poorly differentiated lymphocytic	3) Diffuse poorly differentiated lymphocytic
4) Nodular histiocytic	4) Diffuse histiocytic
	5) Undifferentiated lymphoma

IV). One group<sup>15</sup> found that 81% of patients with positive lymphangiograms had nodal or organ involvement outside conventional radiation therapy fields. This tendency for dissemination to mesenteric lymph nodes or bone marrow explains the high relapse rate in patients treated with total nodal radiation therapy. Consequently, chemotherapy is the primary modality for the non-Hodgkin's lymphomas.

Although there is a high frequency of complete remission and a relatively prolonged survival within the good histology (nodular) non-Hodgkin's lymphomas, these diseases relapse at a rate of 10%-15% annually. The treatment for this group of diseases is controversial since several studies have suggested that single agent chemotherapy may be as effective as more intensive programs in the management of nodular lymphomas with favorable histologies.<sup>16</sup> Nodular, well-differentiated lymphocytic, non-Hodgkin's lymphoma can be treated as effectively with a single alkylating agent as with combination therapy.<sup>17</sup> However, other histological groups in this more favorable category, such as nodular lymphocytic poorly differentiated, nodular mixed histiocytic lymphocytic and nodular histiocytic, show a wide spectrum of clinical response. The combination of cyclophosphamide, vincristine and prednisone (COP) is superior to single agent chemotherapy in the management of this group.<sup>18-19</sup> One study<sup>20</sup> has shown that maintenance therapy is effective in prolonging the duration of remission and survival in patients with non-Hodgkin's lymphomas and has demonstrated that duration of remission was significantly longer with cyclophosphamide maintenance than with methotrexate; response to the latter did not differ with that to placebo. In addition, the combination of daily, oral cyclophosphamide with periodic monthly reinforcement with vincristine and prednisone led to a longer remission and survival when compared to oral maintenance cyclophosphamide. These findings were applicable primarily to the favorable histology group of

the non-Hodgkin's lymphomas. For the unfavorable histology group, no significant difference was noted in the maintenance program.

Results in the treatment of patients who have poor histology (diffuse mixed lymphocytic and histiocytic, diffuse poorly differentiated lymphocytic, diffuse histiocytic lymphomas, undifferentiated lymphocytic lymphoma) have not been encouraging. Cyclophosphamide or vincristine produced transient responses of short duration in approximately 10% of patients.<sup>1</sup> The median survival for patients with Stage III and IV histiocytic lymphomas has been 6 to 9 months with most patients dying within one year of diagnosis.<sup>21</sup>

Numerous clinical trials have shown the superiority of combination therapy for the treatment of the poor histology group of non-Hodgkin's lymphomas. MOPP and C-MOPP (cyclophosphamide, vincristine, procarbazine and prednisone) produce remissions in 41%-48% of patients. CHOP (cyclophosphamide, adriamycin, vincristine and prednisone)<sup>22</sup> has induced remission rates varying from 50% to 80%. The histological type with the least favorable prognosis in this group is the diffuse histiocytic type. However, an improved response frequency and potential for prolonged survival has been found in a subset of this group of patients with Stage III and IV disease. DeVita et al<sup>23</sup> achieved a 41% complete response frequency with either MOPP or C-MOPP with disease-free remission of 41+ months. A more toxic treatment (BACOP<sup>24</sup> — bleomycin, adriamycin, cytoxan, oncovin and prednisone) achieved a 48% complete remission frequency in 12 of 25 patients with diffuse histiocytic lymphoma. This regimen consists of a myelosuppressive phase in which cyclophosphamide, adriamycin and vincristine are employed followed by bleomycin and prednisone. In this study, the initial dose of bleomycin was reduced because of pulmonary toxicity. In contrast to the National Cancer Institute study with MOPP or C-MOPP,<sup>23</sup> continued relapse was seen from 2 to 32

months after complete remission with CHOP.<sup>22</sup> Thus, no trend toward long-term survival was identified in this pathological group.

Central nervous system disease occurs in approximately 25% of patients with non-Hodgkin's lymphomas with less favorable histologies.<sup>25-26</sup> Skarin et al<sup>26</sup> treated 20 patients with advanced less favorable histology non-Hodgkin's lymphomas (16 previously treated with high-dose methotrexate followed by folinic acid rescue. A objective response was seen in 1 patients with complete response in 20%. Five of six patients with central nervous system disease responded to this therapy with three of the five patients completely cleared. Previous pharmacological studies<sup>27</sup> have shown therapeutic central nervous system levels of methotrexate following systemic administration of high-dose methotrexate. Half-life in the central nervous system compartment is 12 to 18 hours compared with serum half-life of 4 to 6 hours after either systemic or intrathecal methotrexate administration.

A thorough reassessment of the patient's disease should be performed following completion of the induction program and the clinical attainment of a complete remission. Patients should be carefully evaluated to insure that areas which were involved with lymphoma at the time of initial treatment have returned to normal. Patients with complete remission after careful reassessment of their disease have not been shown to benefit from maintenance chemotherapy. Low dose chemotherapy appears of little benefit during maintenance in this group of unfavorable histologies. However, intensification of therapy during the observation period remains to be evaluated.

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But by the contrary, if a man smoke himself to death with it (and many have done) O then some other disease must beare the blame for that fault. So do olde harlots thanke their harlotrie for their many yeeres, that custome being healthful (say they) *ad purgandos Renes*, but never have minde how many die of the Pockets in the flower of their youth. And so doe olde drunkards thinke they prolong their dayes, by their swine-like diet, but never remember howe many die drowned in drinke before they be halfe olde. — *A Counter-Blaste to Tobacco*, King James I, 1604.

# Clinical Experience with Copeland Iris Plane Intraocular Lens Implantation

Martin J. Kreshon, M.D., and John A. Young, M.D.

**ABSTRACT** A series of 44 consecutive cases of intracapsular cataract extraction with insertion of the Copeland Iris Plane Intraocular Lens implant is presented. Surgical technique and preoperative and postoperative management are described. Short-term results to date with this group of elderly patients have been gratifying.

**I**NTROOCULAR lens implantation after cataract surgery is a clinically acceptable procedure for the elderly patient. The Food and Drug Administration has recently labeled these lenses as investigative and has instituted a research protocol governing the implantation of every lens in this country. All patients in this study were aware of this fact and signed an informed consent prior to implantation. Although there have been many modifications of intraocular lenses since Ridley's<sup>1</sup> first description in the 1940s, the choice for the ophthalmic surgeon at the present time has been narrowed down to five basic types:

1. Anterior chamber angle fixation lens, such as the Choyce-Tennant lens.

2. The iris fixation lens, wherein the haptic portions of the lens are chiefly supported by the iris with some contribution by the anterior hyalid membrane or by the posterior capsule in cases of extracapsular extraction. These lenses include the Binkhorst, the Epstein, the Copeland and the Fyodorov.

3. Iridocapsular fixation lenses such as the Binkhorst and Fyodorov. These demand an extracapsular cataract extraction.

4. Capsular fixation lenses, which depend on the posterior lens capsule for support. These include the Fyodorov and Kelman hockey-stick lens.

5. The posterior chamber lens. This is a relatively new concept, utilizing the Shering lens.

After evaluating most of the lenses available over the past five years, we decided to implant only one type of lens, the Copeland,<sup>2-5</sup> which offers the following advantages.

1. There is no contact with the anterior chamber angle, thus decreasing the incidence of iridocyclitis, corneal edema, and possible hemorrhage.

2. The lens is positioned much further away from the corneal endothelium than other lenses, thereby lessening the chance of corneal touch. In cases of shallow anterior chamber, only the iris contacts the cornea.

3. Centering by the iris sphincter muscle stabilizes the position of the implant.

4. The implant is less dependent on the configuration of the anterior chamber angle or the depth of the anterior chamber.

5. The lens requires no suture or other type of fixation which might fail at some future time.

6. The lens is gas sterilized and of excellent optical quality. It is available in a number of powers from +8.00 to 30 diopters.

The Copeland implant is shaped like a propeller with the four blades or haptics in the same plane as the round central optical portion. It requires neither suturing nor a switch to the extracapsular technique. It is wedged into the pupillary space in the same plane as the iris, with the two vertical blades behind the iris and the two horizontal blades anterior to the iris. The lens is a polymethylmethacrylate, in the shape of a symmetric cross. The optical portion is approximately 0.38 mm thick and the supports are approximately 0.01 mm thick. The optical portion is 4 mm with a

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erall diameter of 9 mm. The lens available in powers of 11.00 opters to 25.00 diopters in 1/2 opter steps. Special order powers, 00 to 30.00 diopters, are available. In selecting patients for intraocular implant it was felt that the basic consideration would be the presence of a very healthy anterior segment. This would include a normal corneal endothelium; normal anterior chamber depth; no iris atrophy; normal sphincter and dilator function, and a normal intraocular pressure. In addition, the following criteria were used:

1. Lens implantation was restricted to patients 70 years of age or older.
2. A pseudophakos would not be placed in the second eye of a patient until a successful interval of two years had elapsed since lens implantation in the first eye.
3. Exceptions would consist of those patients, in any age group, physically or mentally handicapped (epilepsies, arthritic tremors, macula degeneration, etc.) who had to have cataract surgery and for some reason could not handle contact lenses or aphakic spectacles.
4. No patient with diabetes or glaucoma would be considered.
5. One-eyed patients would not receive the implant.

## TECHNIQUE

Although the technique varied somewhat in our institution, depending on the surgeon involved, a standard intracapsular cataract extraction, with two small iridectomies or iridotomies, placed at about 30 degrees apart, was the rule. Interrupted absorbable sutures were used, and in addition two 10-0 nylon sutures, one at one o'clock and one at eleven o'clock, were placed by one of the authors. Very little variation from standard intracapsular technique occurred. Digital massage was used for at least five minutes on every case and if during the procedure the iris appeared to be bulging after lens delivery, or if there was vitreous in the anterior chamber, the lens was not implanted. It was felt by all of us that intravenous Mannitol is essen-

tial to produce a soft enough eye to prevent abortion.

Preoperative pupillary dilatation was not utilized. Miochol or Miostat was placed in the anterior chamber following delivery of the cataract in all instances and if the pupil did not constrict adequately the lens was not implanted. The lens was inserted after thorough rinsing with balanced salt solution. The six o'clock haptic was inserted beneath the iris first. No guide was used. The horizontal haptics were placed in front of the iris at the three o'clock and nine o'clock position and then the iris was grasped at the twelve o'clock position with either a thin non-tooth forceps or a small iris hook and lifted over the twelve o'clock blade. No steroids were injected subconjunctivally, but this may be considered in the future if posterior pupillary membranes become a problem. So far this has not been a clinical complication.

Postoperatively, the eye is checked one hour after the procedure to insure that the pupil is square and that the implant is centered. The patient is usually not placed on miotics,<sup>6</sup> but occasionally one percent Pilocarpine was used to keep the pupil down the first two days and then discontinued. Topical antibiotic-steroids to decrease iritis were continued for approximately two months.

Calculation of lens power was based primarily on the preoperative K-reading and the refractive history when it was available. The consideration as to whether to make the eye hyperopic or myopic was based on the refractive power of the other eye and the vocational or avocational needs of the patient. An ultrasonic A-scan was not available until late in the series and therefore it was not used. There were no "nine diopter" surprises in this group, but when more facility can be gained in the use of the A-scan it will be used on every case so that this type of surprise can be avoided.

## CLINICAL RESULTS

This report encompasses the clinical histories of 44 patients receiving an implant whose ages ranged from 62 to 90, with an average age of 77 (Fig. 1). The lowest power placed in the pupillary space was 19.00 and the highest power was 21.50. Forty-two patients had planned intracapsular cataract extraction and two patients had planned extracapsular cataract extractions early in the series. Follow-up ranged from two months to two years. Seventy-two percent of our patients obtained corrected vision of 20/40 or better. Those who did not expressed satisfaction with the improvement they did obtain.

Complications were minimal.

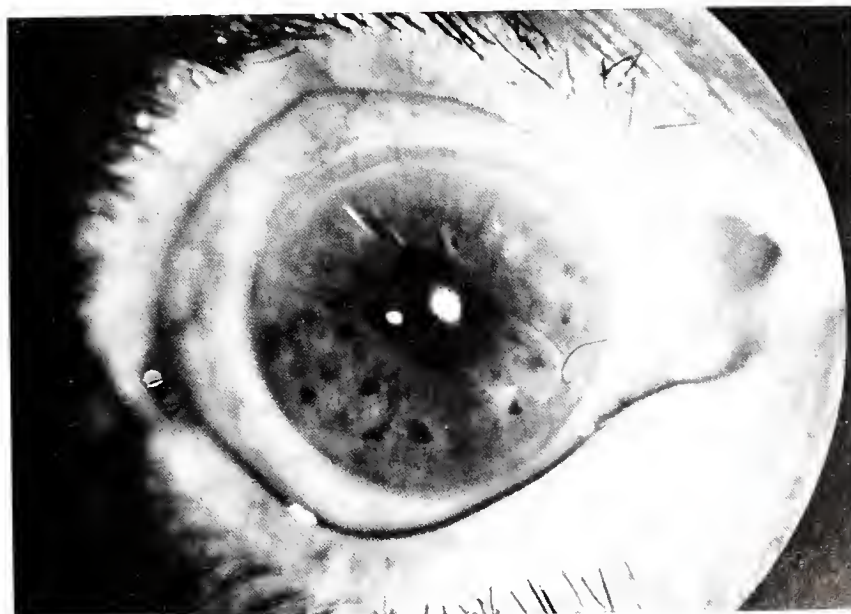


Fig. 1: A 77-year-old male two-months post-operative. Vision 20/30 unaided.

Our patients experienced no corneal edema or cornea touch, no wound complications, no infections or endophthalmitis, no anterior chamber hemorrhage and no retinal detachment.<sup>7</sup> There was one case of glaucoma and one patient experienced dislocation of the lens. A 65-year-old patient bumped his eye while placing drops in it. The lens was repositioned immediately, without any loss of vitreous or disturbance. Vision remains 20/20. Two patients had cystoid macula edema. One now has 20/40 vision with chronic edema of the macula; the other has 20/70 vision. It is interesting that the complications described in the literature,<sup>8</sup> such as

pupillary space membranes, have not been noted. It is our feeling that patient selection, the absence of surgical complications on the table and minimal use of postoperative miotics are factors in decreasing this complication in our series.

The implantation of the Copeland lens, a relatively simple procedure, is certainly easier than using intraocular lens that require either the remnants of the lens cortex or capsule for implant fixation,<sup>9</sup> or the tying of 10-0 Perlon sutures inside the anterior chamber or through the cornea.

The usual problems associated with adjustment to aphakia in this older age group are eliminated, to

the relief of the patient and the surgeon. The level of patient satisfaction is extremely high.

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... such is the miraculous omnipotencie of our strong tasted *Tobacco*, as it cures all sorts of diseases (which never any drugge could do before) in all persons, and at all times. It cures all manner of distillations, either in the head or stomacke (if you believe their Axiomes) although in very deede it doe both corrupt the braine, and by causing over quicke digestion, fill the stomacke full of crudities. It cures the Gowt in the feet, and (which is miraculous) in that very instant when the smoke thereof, as light flies up into the head, the vertue thereof, as heavie, runs downe to the little toe. It helpes all sorts of Agues. It makes a man sober that was drunke. It refreshes a weary man, and yet makes a man hungry. Being taken when they goe to bed, it makes one sleepe soundly, and yet being taken when a man is sleepe and drowsie, it will, as they say, awake his braine, and quicken his understanding. As for curing of the Pockes, it serves for that use but among the pockie Indian slaves. Here in *England* it is refined, and will not deigne to cure heere any other then cleanly and gentlemanly diseases. Omnipotent power of *Tobacco*! And if it could by the smoke thereof chace out devils, as the smoke of *Tobias* fish did (which I am sure could smel no stronglier) it would serve for a precious Relicke, both for the superstitious Priests, and the insolent Puritanes, to cast out devils withall. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Editorial

## MEETING OF THE EXECUTIVE COUNCIL AT MID PINES OCTOBER 1, 1978

Executive councils of medical societies can be accused of being all things to all men; unfortunately, our members demand it. At the October 1, 1978, meeting of the council held as usual at the Mid Pines Club at Southern Pines, it was the task of President D. E. Ward, Jr., to reconcile opposites and to mix incompatibles while maintaining order and facilitating effective discussion. That the council could leave before work testifies that he succeeded, leaving few details attached.

After standing in silent and meditative respect to Dr. Archie T. Johnson, Jr., the council resumed its efforts to attend to Mrs. Robert Means, president of our auxiliary, whose direct and informative report has already appeared in these pages. The ladies in the past year have set an example for good works that their husbands should envy and seek to emulate. Dr. Jesse Caldwell, Jr., then spoke for the Council on Review and Development offering several resolutions acceptable to the council for presentation to the House of Delegates: to abolish the Hospital and Professional Relations Committee, to combine the Committee on Drug Abuse and Pharmacy, to make the Committee on Communications freestanding and its chairman an ex officio member of the council, to transfer the evaluation of insurance programs from the Professional Insurance to the Retirement Savings Plan Committee, to permit the president of the society to appoint a Committee on Religion and Ethics and to allow him to appoint as many members as he deems necessary to each committee, an important action in this era of almost unlimited medical awareness. While seemingly trivial, each of these resolves simplifies the functioning of the society and ultimately will increase our effectiveness.

Dr. Tilghman Herring then approached the podium and deliberately and in well-measured conversational tones had discussed our fiscal position. Unexpected surpluses resulting from sound economic practices indicate that such care in the art of financial husbandry has been exercised to set an example for other organizations, even including governments. Although the budget for 1979 has increased, it is still comfortable even allowing for expanded efforts in communications: to legislators, to the general public and to each other. An ad hoc committee under the aegis of past president Harvey Estes is actively seeking the right

people to improve our communication with the public and the legislature. Later in the day, Dr. Herring was selected to fill the second vice-presidency, vacated when Dr. Albert Stewart became first vice-president in succession to Dr. Johnson; his acceptance speech was as sparing of words as his budget was parsimonious. Dr. David Welton, speaking next for our AMA delegates, pointed out that the term of Dr. John Glasston, currently vice-chairman of the AMA Council on Medical Services, expires next June and urged the Executive Council's endorsement of his campaign for re-election which was offered promptly and with enthusiasm. Before receiving the commissioners for their reports, the council reaffirmed its earlier support of our colleagues in ophthalmology and the efforts to effect repeal of a 1977 Optometric Drug Use Law.

**Annual Convention Commission. Dr. Josephine E. Newell, commissioner.** Seven resolutions relating to medical education were offered and five accepted. These reaffirm our commitment to continuing education, permit more uniformity of categorization of programs and fulfillment, relate to three-year approval of requirements for postgraduate medical education by board certification or recertification, make provision for more representative balance on Dr. John Bridgers' very active committee and approve a pilot study in post-graduate medical education to be carried out by his committee in collaboration with the JOURNAL.

**Advisory and Study Commission. Dr. T. Reginald Harris, commissioner.** Earlier the council had heard from Mrs. Means of the auxiliary whose society advisory committee functions with this commission. Its other committees, seven in number, had been busy but action was required only in a resolution which offered support to the State Highway Department in its efforts to make the laws about drunken drivers more effective. This resolution well illustrates the necessity to attend carefully to the minutiae of management, the essential if seemingly uninteresting tasks so essential for proper functioning of organizations devoted to the general welfare.

**Administrative Commission. Dr. T. Tilghman Herring, commissioner.** The multi-hatted Dr. Herring returned briefly to comment about the four committees under his supervision. The council decided at his urging that it was reasonable and financially sound to buy a car for use by the society staff.

**Public Service Commission. Dr. Philip G. Nelson, commissioner.** The arms of this commission reach into medical aspects of social and political processes be-

yond number. For example, screening for neonatal hypothyroidism was blessed because it is humane as well as cost efficient. Eight of our 86,000 annual newborns will be hypothyroid; if replacement therapy is started promptly, the cost of cretinism is avoided and opportunity for a normal life increased immeasurably. Premarital rubella screening was decried because of cost and inappropriateness for menopausal women or those who have undergone hysterectomy. Retention of premarital testing for syphilis was urged after considerable valuable discussion. The commission also directed its attention to problems about immunization which have been commented on in the publications of the Department of Human Resources and which will receive increasing emphasis in the marketplace.

**Public Relations Commission. Dr. Marshall S. Redding, commissioner.** This body finds its committees in the public arena most of the time, too, not of their own choosing but because medicine has really always been public, since the first devil was exorcised and the first incantation spoken. At this session, besides being very concerned about optometrists, it favored tighter regulation of the licensing of midwives and viewed with legitimate alarm the chaotic state of the state perinatal and crippled children's programs, brought low by confusing financial policies and unrealistic cost projections. Disapproval of blanket generic substitution for prescribed trademark medications was requested of the council because safeguards provided physicians or patients would be insufficient if this were permitted. The council concurred and pointed out that pharmacists and physicians can make appropriate individual arrangements when indicated and that doctors are free to use generic names when prescribing. The use of the Heart-Aid defibrillator was deplored because not enough data were available to permit constructive conclusions about its effectiveness. The non-medical use of the bee sting anaphylaxis kit was specifically disapproved because of the dangers inherent in the use of epinephrine and of the lack of statistically valid data attesting to its value.

**Professional Service Commission. Dr. M. Frank Sohmer, Jr., commissioner.** This commission, comprised of seven committees, is engaged almost con-

stantly on a number of frontiers — insurance, federal and state government, industry and health planning. Because of pressure generated at these points and because of public interest, it is in a particularly critical position. For example, health planning is now a favorite topic, almost a new growth industry as studies multiply and interpretations abound. That HSAs now are instructed to prepare five-year plans is enough to set anyone on edge. Whether having our own fulltime health planner would help any was discussed but no definitive action taken perhaps because who can plan whose health for how long and at what costs. Annual implementation plans on top of five-year plans may become a way of life for some so that the society faced with the problem of how to monitor the quasi-medical bodies.

Medicare and Medicaid payments again require scrutiny and recommendations about certain problems will be presented to the House of Delegates. Mr. Califano's push for a second surgical opinion is a problem which can't be handled so easily. There was much talk, some light and even some heat generated about this before the council opted to take the position of the AMA House of Delegates as recently presented.

"Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the House of Delegates of the American Medical Association (1) reaffirms the right of a patient or physician to seek consultation freely with any consultant of his/her choice, (2) opposes the concept of mandatory consultation when required by a third party payor, (3) supports the concept that when consultation is required by a third party payor, the consultation should be at no cost to the patient, (4) opposes the concept of closed panels of consultants, (5) supports the concept that if consultation is required by a third party payor, the patient should be allowed to choose a physician of his/her choice."

The council by a narrow margin voted to recommend that members of the society not place their names on any closed or open panel listing of physicians who would offer second surgical opinions. (See page 717 for an analysis of the problems presented by plans which ask second surgical opinions.) J.H.F.



# Correspondence

## SURGICAL SECOND OPINIONS

the Editor:

To implement what is called an "experimental cost containment method," Southern Bell and Blue Cross, Blue Shield have agreed on a policy under which Blue Cross, Blue Shield will pay benefits for a "second opinion" consultation for Southern Bell employees before elective surgery. Use of the benefit is entirely voluntary and the patient must initiate the request for second opinion. To that extent, the arrangement is the same as the referral system we have today. However, the plan calls for a list of three specialists in each field of surgery, one of whom will be chosen by the patient as the consulting surgeon.

We believe that that plan will be disruptive of our present referral system. Further, we fear that that plan may lead to mandatory "second opinion" surgery. We know of no study that has shown that "second opinion" surgery leads to a decrease in the cost of medical care. While we recognize that unnecessary surgery is done in some instances, we believe that the PRO audit system, which is already in effect, is much more likely to reduce the incidence of unnecessary surgery than a "second opinion" option.

For those reasons, we have strong reservations about the Southern Bell-Blue Cross, Blue Shield plan. We would like first to address the value of a consulting referral list, and then to express our concern about the effects the "second opinion" option will have on medical practice if the step taken by Southern Bell-Blue Cross, Blue Shield becomes a trend. That concern is not ours alone; it is expressed at every meeting of local, regional and national medical societies.

The mechanism for obtaining a second opinion on the need for surgical intervention is already well established. It is used daily and successfully in our current practice of medicine, and it allows us to refer patients to surgeons whom we know and whose skills and opinions we know and respect. Such familiarity with the surgeons may not be possible with the use of an assigned list.

From the patient's standpoint, second opinions do not fail to add some degree of mistrust in the first physician, albeit slight and unintended. Any deviation from the customary referral system, such as making it more structured or making a second opinion mandatory, is apt to further that distrust. That problem may be particularly acute if the referring physician is using a new technique with which the consulting surgeon is not familiar or of which he does not approve. Then the second opinion becomes: "Yes, you do need the op-

eration but, no, I would not do it by Dr. A's method." In such instances, we foresee that "second opinion" surgery could become a deterrent to the development of new techniques that are essential to the progress of surgery.

We believe that the inclusion of only three names on the referral list will make it impossible for the patient to get a second knowledgeable opinion on certain surgical diseases that are not well understood by all practitioners in the same specialty. The surgical specialties have become so subspecialized that the knowledge and experience of one surgeon in certain geographical areas cannot be duplicated readily by that of another surgeon. That is particularly true of a relatively rural state such as North Carolina.

The Southern Bell-Blue Cross, Blue Shield plan allows a consultant to decline to examine a particular patient but does not give the referring physician the option of suggesting that his patient not see one of the consultants on the referral list. While we know that care will be taken to choose outstanding consultants in each field, we also know that there will be occasions when, for personal reasons, a referring physician will prefer that a specific consultant not be the one to see his patients for a second opinion.

While the aim of Blue Cross, Blue Shield is to provide low-cost medical care to a large number of subscribers, we presume that they are also interested in providing the best in medical care. If two opinions are *a priori*, better than one opinion, then Blue Cross, Blue Shield — and other third party carriers, as well — should be willing to pay for a second opinion when the first opinion is that *no* operation is necessary. In other words, there is no way to ensure that the second opinion will be better for the patient than the first. If a third opinion is sought — and the Southern Bell plan allows for it if the first two opinions differ — we do not believe that Blue Cross, Blue Shield will absorb that cost indefinitely if more patients choose the second opinion option.

Quite often, the differences in opinion are on the matter of timing. If, on the basis of a second opinion, an operation is not prevented but is merely postponed, then no money is saved. In fact, once the postponed operation is done, more money may be spent if (1) the present escalation in medical costs continues and (2) expensive complications occur or a longer hospitalization is required because the patient is then older and perhaps more debilitated by his disease. We are afraid that only the first prevention of unnecessary surgery will be publicized, rather than a reporting of whether

such "unnecessary" surgery later became necessary. Controversy over the study in New York State and the report by the Moss Subcommittee have demonstrated the damage of such publicity to the medical profession.<sup>1-3</sup>

While we believe we should cooperate with Southern Bell's plan, we are convinced that the solutions to the problem of unnecessary surgery should lie with the medical profession. We find it distasteful to have imposed upon us, by a third party carrier, a system that has not yet been found to be effective either in terms of reducing the cost of medical care or in terms of improving that care. We do not approve of unnecessary surgery, but we believe that unnecessary surgery is responsible for an extremely small portion of the problem of escalating medical costs.

We believe that the medical profession, rather than conceding to the demands of third party carriers, should take a very strong position regarding "second opinion" surgery. It is our duty, and our right, to correct that problem among ourselves. We should educate the public and the third party carriers, including Blue Cross, Blue Shield, about our present system for second opinion referrals, clearly delineating the present mechanism. If the third party carriers still insist on a second opinion, we, in turn, should insist on a well-controlled, nondisruptive, nonpanel or nonlist, peer-group referral system.

We should also initiate and ask the third party carriers to support a prospective study on the cost effectiveness of the second opinion option, a study care-

fully prepared by both physicians and statisticians. Such a study will take years, because patients not undergoing surgery on the basis of a second opinion and patients having an operation on the basis of a second opinion must be studied for as long as there are relevant follow-up data.

We look on the Southern-Bell-Blue Cross, Blue Shield plan as another example of the attempt of non-medical organizations to alter our medical care system. Certainly, there are many aspects of that system that can be improved. However, we must be the ones who take the initiative in that matter or the ones who share in that initiative, not the ones upon whom an unproved plan is forced. We should find out the true value of second opinion for surgery, that is, whether it does, in the long run, improve health care and reduce the cost of that care. Not only is it our responsibility to settle that matter, it is our right to do so. We should be sure to guarantee ourselves that right.

DAVID L. KELLY, JR., M.D.

Professor of Neurosurgery

RICHARD T. MEYERS, M.D.

Professor and Chairman

Department of Surgery

Bowman Gray School of Medicine

Winston-Salem, N.C. 27103

#### References

1. McCarthy EG, Widmer GW: Effects of screening by consultants on recommended elective surgical procedures. *N Engl J Med* 291 1331-1335, 1974.
2. Subcommittee on Oversight and Investigations of the House of Representatives, Hearings on Cost and Quality of Medical Care. Congressman John E. Moss, Chairman.
3. Phuetze KD: "Unnecessary" surgery. Scientifically erroneous testimony in Massachusetts subcommittee hearings. *NY State J Med* 76 2198-2203, 1976.

Medicine hath that vertue that it never leaveth a man in that state wherein it findeth him: it makes a sicke man whole, but a whole man sicke. And as Medicine helpes nature being taken at times of necessitie, so being ever and continually used, it doth but weaken, wearie, and weare nature. What speak I of Medicine? Nay let a man every houre of the day, or as oft as many in this countrey use to take *Tobacco*, let a man I say, but take as oft the best sorts of nourishments in meate and drinke that can be devised, hee shall with the continuall use thereof weaken both his head and his stomacke: all his members shall become feeble, his spirits dull, and in the end, as a drowsie lazy belly-god, he shall evanish in a Lethargie. — *A Counter-Blaste to Tobacco*, King James I, 1604.



# Bulletin Board

## NEW MEMBERS of the State Society

## WHAT? WHEN? WHERE? In Continuing Education

kins, Neal Ashley, MD, (OBG) 3803 Computer Dr., Raleigh 7609  
 trand, Margaret Lins, MD, (R) Rt. 1, Box 347-BB, Huffman Lane, Burlington 27215  
 one, Scott A. (STUDENT) 734 McCauley St., Chapel Hill 27514  
 sken, Donald William, MD (FP) 400 Randolph Rd., Thomasville 7360  
 idy, Charles Eldon, Jr., MD, UNC Student Health Serv., Chapel Hill 27514  
 andang, Napoleon Veluz, MD, (OM) Western Electric, Box 5000, Greensboro 27420  
 apman, Charles G., MD, (RENEWAL) 6134 Deveron Dr., Charlotte 28211  
 rin, Kerry Alan, MD, (GS) Rt. 4, Box 583, Thomasville 27360  
 ements, Dennis Alfred, III, MD, (PD) 306 S. Gregson Street, Durham 27701  
 eon, Rosemary Espino, MD, (AN) 5337 Edington Lane, Raleigh 7604  
 lin, Robert Alexander, Jr., MD, (CD) 809 Hillcrest Dr., High Point 27262  
 ischek, Stephen David, MD, (IM) 1032 College St., Oxford 7565  
 wanik, Joseph John, MD, (ORS) 1925 Clematis Place, Charlotte 8211  
 cher, Gary Jay, MD, (R) 3009 Lake Forest Dr., Greensboro 7408  
 witt, Gerald Thomas (STUDENT), P.O. Box 7547, Raleigh 7611  
 rper, John Michael, MD, (IM) 502 7th Avenue, W., Hendersonville 28739  
 ton, William Charles, MD, (CDS) 1300 St. Mary's St., Ste. 220, Raleigh 27605  
 mbrough, Houston Magill, Jr., MD, (U) 203 Parkmont Dr., Greensboro 27408  
 vder, John Henry (STUDENT) 1013-B Brownlea Dr., Greenville 27834  
 enzner, Paul Scott, MD, (ORS) 200 Doctors Dr. Ste. J., Jacksonville 28540  
 ces, Walter Jerry, MD, (NS) Box 3807, Duke Med. Ctr., Durham 7710  
 ham, Sumner Malone, Jr., MD, (OBG) Kinston Clinic, N. Ste. 1, Kinston 28501  
 onson, Linda Moore, (RENEWAL) 1 Forest Lane, Asheville 3805  
 enberg, Stanley Joseph, MD, (AN) 1708 Milan Rd., Greensboro 7401  
 chez, Alexander Francis, Jr., MD, (FP) 1000 Blythe Avenue, Charlotte 28234  
 uggs, Thomas Murphy, MD, (U) 617 College St., Jacksonville 8540  
 iano, Clinton Reyes, MD, (GS) 1806 S. Hawthorne Rd., Winston-Salem 27103  
 in, Stephen Richard, MD, (D) 1302 Ashley Avenue, High Point 7260  
 tehurst, Lee Albert, MD, (ORS) 3515 Glenwood Ave., Raleigh 7608  
 osky, Bernard Raymond, Jr. (STUDENT) Duke Med. Ctr. Box 2877, Durham 27710  
 tenberg, Peter Herbert, MD, (PTH) Gaston Mem. Hosp., Gastonia 28052

Please note: 1. The Continuing Medical Education Programs at Bowman Gray, Duke, East Carolina and UNC Schools of Medicine, Dorothea Dix, Wayne County Hospital, Burroughs Wellcome Company and Craven County Memorial Hospital are accredited by the American Medical Association. Therefore CME programs sponsored or co-sponsored by these schools automatically qualify for AMA Category I credit toward the AMA's Physician Recognition Award, and for North Carolina Medical Society Category A credit. Where AAFP credit has been requested or obtained, this also is indicated.

2. The "place" and "sponsor" are indicated for a program only when these differ from the place and source to write "for information."

### PROGRAMS IN NORTH CAROLINA

#### January-February

1st District Medical Society Postgraduate Course

Place: Edenton, Ahoskie

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### January 10

Immunological Aspects of Malignancy

Place: Pitt County Memorial Hospital, Greenville

Fee: \$15

Credit: 3 hours; AMA Category I

For Information: F. M. Simmons Patterson, Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### January 17

Wingate Johnson Memorial Lecture

Fee: None

Credit: 2 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27104

#### January 17

Office Recognition and Management of Sexual Dysfunction

Place: Flame Steak House, Sanford

Sponsors: Lee County Medical Society and Wake AHEC

Fee: \$6

Credit: 3.5 hours

For Information: R. S. Cline, M.D., Director of Continuing Medical Education, Lee County Hospital, Sanford 27330

#### January 26-27

Urology Postgraduate Course

Fee: \$100

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27104

#### February 1-3

Womack Surgical Society Meeting

Place: Berryhill Hall

For Information: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill 27514

### February 2-3

North Carolina Conference for Medical Leadership  
Place: Sheraton Crabtree Motor Inn, Raleigh  
Sponsors: North Carolina Medical Society  
For Information: Mr. William N. Hilliard, Executive Director,  
North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

### February 14

Psychopharmacology Update  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category 1  
For Information: F. M. Simmons Patterson, M.D., Assistant Dean  
for Continuing Education, East Carolina University School of  
Medicine, Greenville 27834

### February 16-20

Basic Electroencephalography  
Credit: 30 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Con-  
tinuing Medical Education, Duke University Medical Center,  
Durham 27710

### February 19-23

Microvascular Surgery Workshop  
Credit: 40 hours  
For Information: Malcolm H. Rourke, Jr., M.D., Director, Con-  
tinuing Medical Education, Duke University Medical Center,  
Durham 27710

### March 3-4

Anesthesiology  
For Information: David Brown, M.D., Department of Anesthesiol-  
ogy, UNC School of Medicine, Chapel Hill 27514

### March 7-10

Internal Medicine 1979  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Edu-

cation, 236 MacNider Building 202-H, UNC School of Medicine,  
Chapel Hill 27514

### March 8-10

Internal Medicine — 1979  
For Information: William Wood, M.D., Office of Continuing Edu-  
cation, 236 MacNider Building 202-H, UNC School of Medicine,  
Chapel Hill 27514

### March 9-10

2nd Outcome Workshop  
Place: Berryhill Hall  
For Information: William Wood, M.D., Office of Continuing Edu-  
cation, 236 MacNider Building 202-H, UNC School of Medicine,  
Chapel Hill 27514

### March 9-10

Frank R. Lock Symposium in Obstetrics and Gynecology  
Fee: \$125  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Con-  
tinuing Education, Bowman Gray School of Medicine,  
Winston-Salem 27104

### March 14

Recent Advances in Surgical Care  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours; AMA Category 1  
For Information: F. M. Simmons Patterson, M.D., Assistant De-  
an for Continuing Education, East Carolina University School  
of Medicine, Greenville 27834

### March 24

Our Adolescents, Their Changing World  
Place: Babcock Auditorium, Bowman Gray School of Medicine  
Sponsors: Forsyth County Auxiliary, North Carolina State Aux-  
iliary and the North Carolina Medical Society  
For Information: Mrs. Mary Jane Means, P.O. Box 27167, Raleigh  
27611

### March 29-30

Annual Cancer Research Symposium  
For Information: William Wood, M.D., Office of Continuing Edu-  
cation, 236 MacNider Building 202-H, UNC School of Medicine,  
Chapel Hill 27514

### March 31-April 1

4th Annual Radiology Update  
Fee: \$50  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Con-  
tinuing Education, Bowman Gray School of Medicine,  
Winston-Salem 27104

### April 2-6

7th Annual Tutorial — Radiology of the Chest  
Sponsor: The Department of Radiology, Duke University School  
of Medicine  
Credit: 30 hours  
For Information: Robert McLelland, M.D., Radiology-Box 380  
Duke University School of Medicine, Durham 27710

### April 2-6

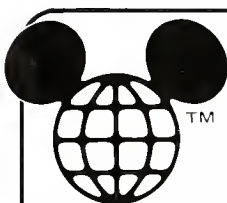
Chest Radiology  
Place: Ramada Inn, Durham  
Fee: \$300  
Credit: 30 hours  
For Information: Robert McLelland, M.D., Radiology Box 380  
Duke University Medical Center, Durham 27710

### April 6-7

Practical Pediatrics  
Fee: \$35  
Credit: 10 hours  
For Information: Emery Miller, M.D., Associate Dean for Con-  
tinuing Education, Bowman Gray School of Medicine,  
Winston-Salem 27104

### April 11

Current Clinical Problems in Family Practice  
Place: Pitt County Memorial Hospital, Greenville  
Fee: \$15  
Credit: 3 hours



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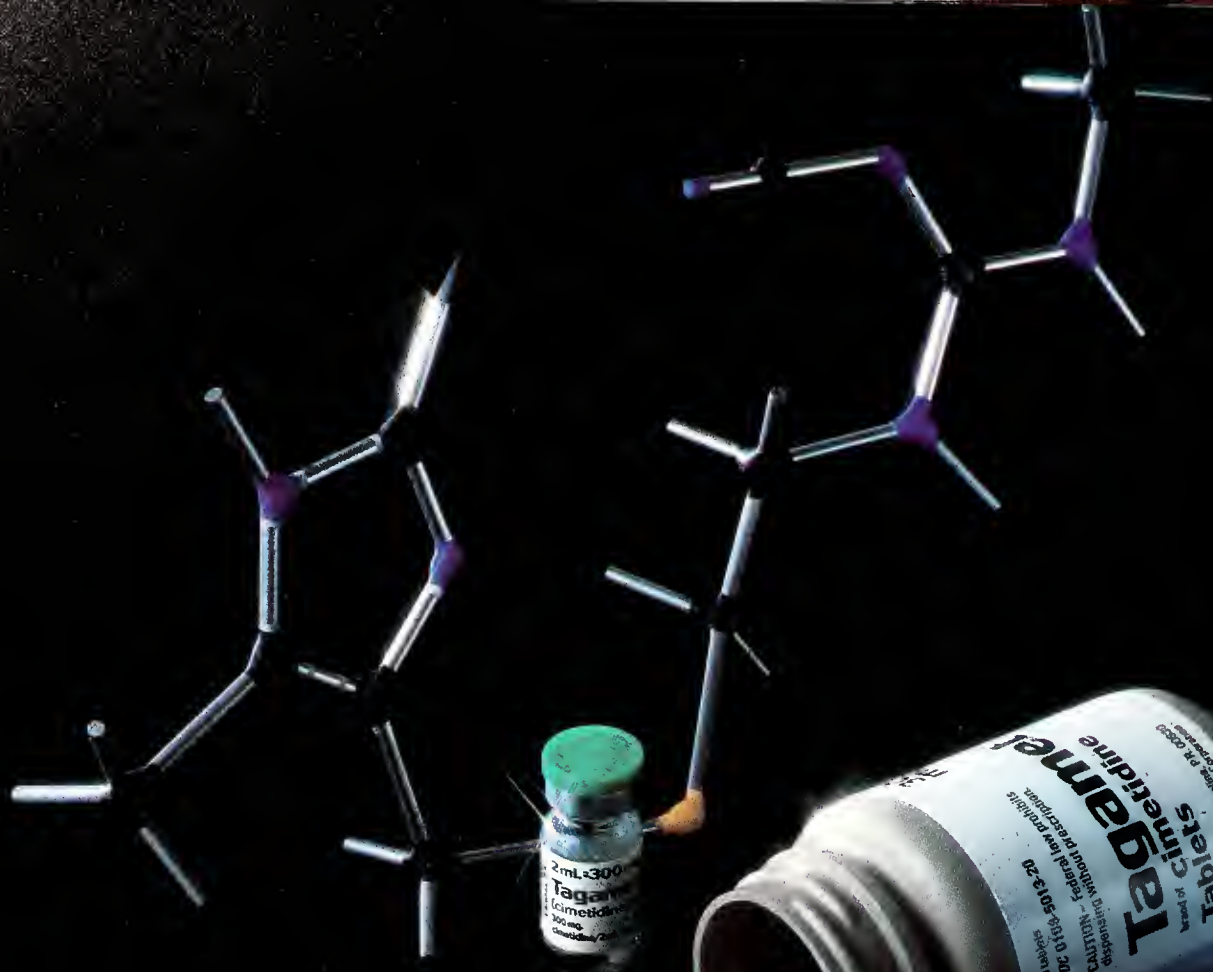
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For Information: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville 27834

#### April 12

2nd Annual Medical Symposium — Greensboro Academy of Medicine

Place: Jefferson Standard Club  
Fee: None

Credit: 6 hours AMA Category I and AAFP

For Information: Robert M. Gay, M.D., Moses Cone Memorial Hospital, Greensboro 27420

#### April 18-20

Rainey Orthopedic Lectures

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 20-22

Spring Radiology Seminar

Place: Berryhill Hall

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building, 202-H, UNC School of Medicine, Chapel Hill 27514

#### April 27-28

Perspectives on Pain Management

Fee: \$100

Credit: 12 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27104

#### April 27-28

21st Malignant Disease Symposium

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### May 2-3

Annual Meeting of the North Carolina Thoracic Society

Place: Royal Villa, Raleigh

For Information: Mr. C. Scott Venable, Executive Director, North Carolina Lung Association, P.O. Box 127, Raleigh 27602

#### May 3-6

25th Annual Session of the North Carolina Medical Society

Place: Pinehurst Hotel and Country Club, Pinehurst

For Information: William N. Hilliard, Executive Director, North Carolina Medical Society, P.O. Box 27167, Raleigh 27611

#### May 9-10

Respiratory Care Symposium: Breath of Spring 1979

Fee: \$35

Credit: 10 hours

For Information: Emery Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27104

#### May 18-19

11th Annual Course in Perinatology

For Information: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill 27514

#### May 23-25

North Carolina Heart Association Annual Meeting and Scientific Session

Place: Winston-Salem Hyatt House

For Information: North Carolina Heart Association, 1 Heart Circle, Chapel Hill 27514

### ITEMS OF SPECIAL INTEREST

#### February 12-16

Current Concepts in Diagnostic Radiology

Place: Acapulco Princess Hotel, Mexico

Sponsor: Department of Radiology, Duke University Medical Center

Fee: \$250

For Information: Robert McLelland, M.D., Radiology Box 3808, Duke University Medical Center, Durham 27710

#### March 5-8

18th National Conference of the Detection and Treatment of Breast Cancer

Place: Atlanta, Georgia

Sponsor: American College of Radiology

For Information: American College of Radiology, 6900 Wisconsin Avenue, Chevy Chase, Maryland 20015

#### May 6-10

2nd International Symposium on Adolescent Medicine

Place: Mayflower Hotel, Washington, D.C.

Sponsor: The Society for Adolescent Medicine

Fee: \$150

For Information: The Institute for Continuing Education, P.O. Box 11083, Richmond, Virginia 23230

#### June 29-30

Medical Horizons: Hypertension and Cardiovascular Disease

Place: Myrtle Beach, South Carolina

Credit: 10 hours

For Information: Emery C. Miller, M.D., Associate Dean for Continuing Education, Bowman Gray School of Medicine, Winston-Salem 27104

### Abdominal Real Time Sonography Courses

A series of six week-long courses on the use of Real Time Ultrasound in abdominal studies will be offered at Bowman Gray School of Medicine on the following dates: March 12-16, June 11-15, July 16-20 and December 9-13, 1979. Participants will receive 30 hours of Category I credit per week.

For Further Information, please contact, James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem 27103

### PROGRAMS IN CONTIGUOUS STATES

#### February 19-23

3rd Annual Review of Internal Medicine

Place: The University of Tennessee, Memphis

Credit: 35 hours

For Information: Dennis K. Wentz, M.D., The University of Tennessee Center for the Health Sciences, 62 South Dunlap Street, Memphis, Tennessee 38163

#### February 23-24

Virginia Chapter of the American Academy of Pediatrics Annual Meeting

Place: Williamsburg, Virginia

For Information: Douglas E. Pierce, M.D., 1201 Third Street, S.W., Roanoke, Virginia 24016

### News Notes from the—

## BOWMAN GRAY SCHOOL OF MEDICINE

## WAKE FOREST UNIVERSITY

Dr. David L. Kelly Jr., professor of neurosurgery at the Bowman Gray School of Medicine, has been named chief of the Section on Neurosurgery.

He succeeds Dr. Eben Alexander Jr., who relinquished his administrative duties in order to devote fulltime to patient care, teaching and research. Alexander, a professor of neurosurgery, was named chief of neurosurgery in 1949.

Kelly, who joined the Bowman Gray faculty in 1965, is the current president of the Congress of Neurological Surgeons, the world's largest neurosurgical society. The congress has a membership of 1,900 neurosurgeons from 36 countries.

He is a former secretary of the congress, a past

president of the North Carolina Neurosurgery Society and a former vice president of the Southern Neurosurgical Society.

Kelly holds the B.S. and M.D. degrees from the University of North Carolina at Chapel Hill.

He was named professor of neurosurgery last summer.

\* \* \*

Dr. Robert C. Pope of Wilson has been installed as president of the Bowman Gray Alumni Association. The installation came during the school's alumni banquet.

Dr. C. James Walton Jr. of Lenoir was elected president-elect and Miss Katherine Davis, assistant to the director of the Bowman Gray/Baptist Hospital Medical Center, was re-elected secretary.

Elected to the association's Alumni Council were Dr. Charles R. Duncan Jr. of Greenville, S.C.; Dr. Ozmer L. Henry Jr. of Black Mountain; Dr. John C. Reece of Morganton and Dr. Robert A. Team of Lexington.

Three members of Bowman Gray's Class of 1953 were recognized as Distinguished Alumni Lecturers. Receiving the recognition were Dr. Paul P. Griffin, professor and chairman of the Department of Orthopedics and Rehabilitation at Vanderbilt University Medical Center; Dr. William B. Herring, associate professor of medicine and chief of the University of North Carolina teaching program at Moses H. Cone Memorial Hospital; and Dr. Julian F. Keith, professor

and chairman of Bowman Gray's Department of Family Medicine.

Distinguished Service Awards were presented to Dr. Livingston Johnson of Shelby, outgoing president of the Alumni Association, and to Dr. D. E. Ward of Lumberton, chairman of the Alumni Division of the Medical Center Challenge Fund.

\* \* \*

First-year medical students at Bowman Gray who have been elected class officers are Richard L. Rauck of San Francisco, Calif., president; Frederick C. Beck of Wadesboro, vice president; Thomas C. Wall of Lexington, secretary; and Miss Diane M. Ludwig of Canyon Country, Calif., treasurer.

\* \* \*

The Bowman Gray School of Medicine is heading a research project involving 4,000 school children in Winston-Salem and Forsyth County aimed at getting accurate information on some of their physical characteristics.

Information received by the researchers will permit a comparison of those characteristics with statistics on youngsters nationwide.

The measurements to be taken are height, weight and an estimate of body fat content.

The project is a joint effort involving Bowman Gray's Section on Community Medicine and the Department of Medical Social Sciences, researchers at Wake Forest University, nutritionists and nurses at

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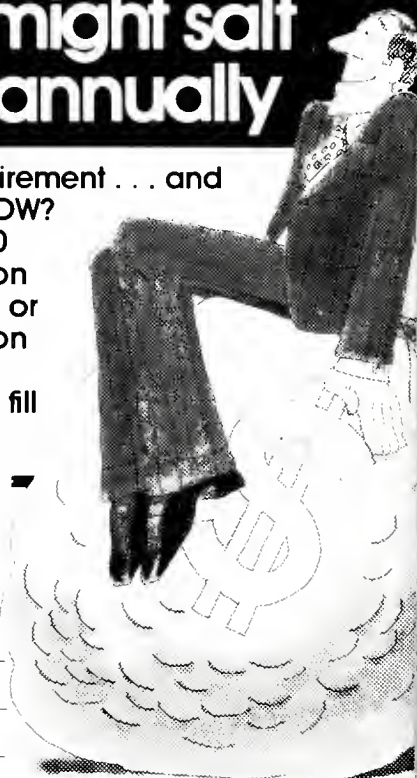


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the Forsyth County Health Department.  
Money for the study has come from a Bowman Gray  
fund to which the North Carolina United Way con-  
tributes.

\* \* \*

Work is under way on the demolition of the original  
building at North Carolina Baptist Hospital, Bowman  
Gray's principal teaching hospital.

Old Main, which opened as an 80-bed hospital in  
1923, will make way for the medical center's Focus  
building. The building will be used for administrative  
and academic offices.

Demolition is to be complete by early winter and  
construction of the Focus Building is expected to take  
about 21 months.

\* \* \*

Dr. Clark E. Vincent, retired professor of medical  
sociology at Bowman Gray, has received the "Dis-  
tinguished Pioneer Award" from the American Associa-  
tion for Marriage and Family Therapy.

Vincent, who retired last spring after 14 years on the  
Bowman Gray faculty, is an internationally known  
authority on marital and sexual health.

His award cites him as a "distinguished social re-  
searcher on sexual and marital problems, energetic  
champion of enlightened marital and sexual educa-

tion, indefatigable administrator and organizational  
statesman, gentle and sympathetic teacher and col-  
league, and pioneer of interprofessional cooperation  
in the promotion of marital and sexual health."

Vincent is a former president, vice president and  
member of the board of directors of the association,  
which previously was known as the American Associa-  
tion of Marriage and Family Counselors.

\* \* \*

Dr. Phillip M. Hutchins, associate professor of  
physiology (biomedical engineering), has been elected  
to the Medical Advisory Board of the Council for High  
Blood Pressure Research.

\* \* \*

Dr. Joseph E. Johnson III, professor and chairman  
of the Department of Medicine, has been appointed  
representative to the Council of Academic Societies of  
the Association of American Medical Colleges by the  
Association of Professors of Medicine.

\* \* \*

Dr. George Podgorny, clinical associate professor  
of surgery, has been elected president of the American  
College of Emergency Physicians.



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Dr. George D. Rovere, associate professor of orthopedic surgery, has been appointed a member of the *Physician and Sportsmedicine* editorial research panel.

\* \* \*

Dr. James F. Toole, professor and chairman of the Department of Neurology, has been appointed secretary-treasurer of the American Neurological Association. He also has been reappointed to the Subcommittee on Stroke of the American Heart Association, appointed to the Task Force on Arteriosclerosis of the National Heart, Lung and Blood Institute, and appointed chairman of the Peripheral and Central Nervous System Drugs Advisory Committee of the Federal Drug Administration.

\* \* \*

Dr. John Ureda, instructor in family and community medicine, has been appointed to the American Heart Association's Subcommittee on Nutrition.

#### News Notes from the

### UNIVERSITY OF NORTH CAROLINA- CHAPEL HILL SCHOOL OF MEDICINE AND NORTH CAROLINA MEMORIAL HOSPITAL

Researchers in the UNC-CH School of Medicine have received a \$26,000 grant from the National Institute of Neurological and Communicative Disorders and Stroke to study a computer-assisted technique that allows scientists and physicians to observe the flow of cerebral spinal fluid surrounding and protecting the brain and spinal cord.

Being able to recognize disturbed or unusual flow of the cerebral spinal fluid may be beneficial in determining the exact location of disease and in distinguishing between diseases in and around the brain, said Dr. Leon Partain, principal investigator. Partain is a research associate in radiology and adjunct assistant professor of surgery.

Researchers will inject the region around the spinal cord of monkeys with metrizamide, a water-soluble contrast material. Because the metrizamide is opaque to x-rays, the scientists will be able to watch the flow through computed tomography.

Others involved in the project include Drs. M. S. Mahaley, neurosurgery, J. D. Mann, neurology, and J. H. Scatliff and E. V. Staab, radiology.

\* \* \*

Researchers at the UNC-CH School of Medicine have received a \$1.8 million, five-year grant from the National Institute of Allergy and Infectious Diseases to continue studies on some sexually transmitted infectious diseases.

Dr. P. Frederick Sparling, professor of medicine and bacteriology and project director, said the research focuses primarily on the bacterium that causes gonorrhea, called the gonococcus, and on the organism that causes syphilis.

The purpose of the research is to permit greater understanding of the biology of infecting organism and the host response to infection and to provide better means of diagnosis, treatment and prevention.

Other faculty involved in the research are Drs. Harry Gooder, bacteriology; Lawrence Guymon, medicine; Terrence Lee, medicine; Joel Baseman, bacteriology and James Folds, bacteriology, associate director of the medical school's clinical microbiology laboratories and director of its clinical immunology laboratory.

\* \* \*

Faculty presenting papers at the Herpes Virus Workshop in Cambridge, England, included: Dr. Joseph S. Pagano, medicine and bacteriology and immunology and director, Cancer Research Center, "The Epstein-Barr Virus — Some Prospects for Research"; Dr. James Shaw, bacteriology and immunology, "Nucleosomal Structure of Epstein-Barr Virus in Transformed Cell Lines"; Dr. John Nedrud, Cancer Research Center, "Demonstration of a Probable Cellular Basis for MCMV Susceptibility Using Trachial Ring Organ Culture"; Brenda Colby, bacteriology and immunology, "Immune Response to EBV-Induced Cell Surface Alteration" and Christine Biron, bacteriology and immunology, "Effect of Acycloguanosine on Epstein-Barr Virus DNA Replication."

\* \* \*

Dr. Suzann K. Campbell, physical therapy, was awarded the Golden Pen Award of the American Physical Therapy Association at its 54th annual conference in Las Vegas. She received the award for advancing physical therapy through her contribution to the APTA's official publication, *Physical Therapy*. Particular recognition was given for the article "Planning Infant Learning Programs" and "Development of Psychomotor Objectives for Classroom and Clinical Education in Physical Therapy," of which she was a senior author, and for "Physical Therapy Programs for the Pediatric Cardiac Surgical Patient," which she co-authored.

\* \* \*

Dr. Jawahar N. Ghia, anesthesiology, presented three lectures at the Second World Congress on Pain in Montreal.

\* \* \*

Dr. Jan Hermans, biochemistry, participated in workshop on "Molecular Dynamics of Polymers" in Orsay, France.

Dr. Richard V. Wolfenden, biochemistry, presented a plenary lecture at the Post-Congress Symposium.



posium on Anti-metabolites in Prague, Czechoslovakia.

Dr. Mary Ellen Jones, biochemistry, chaired a session on enzyme mechanisms at the Martin D. Kamen Symposium, "From Cyclotrons to Cytochromes", at the University of California, San Diego at La Jolla.

\* \* \*

Dr. Christopher C. Fordham III, dean of the School of Medicine and vice chancellor for health affairs, has been elected to the National Academy of Sciences' Institute of Medicine. Fordham is one of 39 professionals selected this year from the fields of health and medicine. He joins three other UNC-CH faculty members in the institute: Dr. Bernard Greenberg, dean of the School of Public Health and Kenan professor of biostatistics, Dr. Cecil Sheps, professor of social medicine, and Dr. Carl Gottschalk, Kenan professor of medicine and physiology.

\* \* \*

Dr. George Johnson Jr., surgery, presented "Treatment of Chronic Venous Insufficiency" to the General Congress Committee for the European-American Symposium on Venous Diseases in Zurich, Switzerland.

\* \* \*

Drs. Paul L. Munson and Tai-Chan Peng, pharmacology, attended the 7th International Congress of

Pharmacology in Paris. Munson was co-chairman of a symposium on "The Pharmacology of Calcium Homeostasis" and Peng chaired a session on "Calcium Metabolism-Calcitonin." Peng also received a travel award from the American Society for Pharmacology and Experimental Therapeutics and presented "Hypersecretion of Calcitonin and C-Cell Hyperplasia in Rats Chronically Exposed to Lead" at the meeting. The paper was co-authored by Drs. S. C. Garner, pharmacology, H. J. Gitelman, medicine, and P. Petrusz, anatomy.

\* \* \*

The School of Medicine recently unveiled a photographic tribute to its three scientists who 25 years ago developed the laboratory test that made possible the diagnosis and treatment of various forms of hemophilia. The black and white photograph, a portrait of Drs. Robert Langdell, Robert Wagner and Kenneth Brinkhous, was taken by the internationally renowned photographer, Yousef Karsh. His work includes a portfolio of physicians and scientists, "Healers of Our Age."

\* \* \*

Dr. Isaac M. Taylor has been appointed research professor in the department of community medicine and hospital administration. He was dean of the medical school here from 1964 until 1971. He returns to

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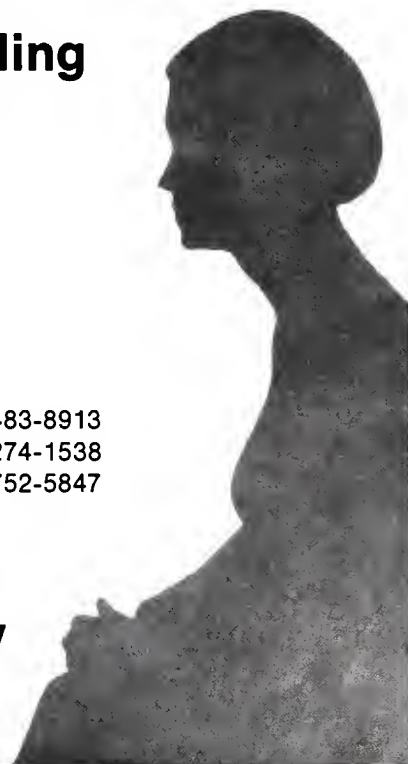
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Chapel Hill from Boston where he has been a practicing physician for several years.

In addition to Taylor's appointment in the recently established department of community medicine and hospital administration, he also was named an adjunct professor in the department of medicine.

In 1976 the School of Medicine presented its highest honor to Taylor, the Distinguished Service Award.

\* \* \*

Kenneth Bott, Ph.D., of the School of Medicine has been awarded a \$58,000 National Science Foundation grant. Bott, associate professor of bacteriology and immunology, and his research graduate student Charles Moran, are studying the organization of ribosomal genes in the chromosomes of a common soil bacterium.

Bott and Moran will investigate why some genes need to be close to identical copies of themselves, why more than a single copy of some genes is necessary and how the sequences of genes are regulated. These factors, Bott said, are of crucial significance for understanding how growth and development of multicellular organisms are controlled.

\* \* \*

William H. Pearlman, Ph.D., a professor in the department of pharmacology, has received \$55,401 from the National Science Foundation for the first year of his three-year study, "Adrenocortical Hormone

Metabolism in Mammary Gland." He is exploring the mechanism by which estrogen prevents milk formation. This occurs during pregnancy, or after delivery when estrogen is given to a mother not electing to breast-feed her infant.

\* \* \*

William B. Guilford, M.D., assistant professor of radiology, has been elected to a two-year term as president of the newly formed Southeastern Society of Skeletal Radiology. Guilford, who heads the UNC-CH division of skeletal radiology, earned his A.B. and M.D. degrees at UNC-CH. In 1976 he was special fellow in bone radiology at the New England Medical Center Hospital of Tufts University School of Medicine and later served as an honorary clinical assistant of orthopaedic radiology at the Royal National Orthopaedic Hospital in London, England.

\* \* \*

Ronald G. Thurman, Ph.D., a pharmacologist at the School of Medicine, has received a five-year, \$175,000 Research Scientist Career Development Award from the National Institute on Alcohol Abuse and Alcoholism. The grant will provide salary support for Thurman, 36, who is conducting two alcohol-related projects.

\* \* \*

#### Appointments:

New assistant professors are: Stanley Lipper, Department of Pathology; Daphne C. McKee, Department of Psychiatry; Thomas W. Traut, Department of Biochemistry and Nutrition; Joan C. Rogers, medical allied health professions; James J. Brickley, Departments of Neurology and Surgery; John Burnett Jr., Department of Obstetrics and Gynecology; Kenneth L. Cohen, Department of Ophthalmology; Timothy W. Lane, Department of Medicine, and Jerome King, Department of Surgery.

Lipper has been serving as a senior fellow and part-time instructor in neuropathology, ophthalmopathology and surgical pathology since 1977. McKee, a native of Morganton, has been a visiting assistant professor since 1977 and has been an adjunct assistant professor since August in the Department of Psychology. She also has been serving as a child psychologist at the Children's Psychiatric Institute in Butner. Traut has been a postdoctoral fellow at the National Institutes of Health since 1976 and has served as a research associate at the University of Southern California. Rogers comes to UNC-CH from the State University of New York at Buffalo where she was a research associate professor of occupational therapy in the School of Health Related Professions. Brickley was a graduate research assistant in the Department of Neurology at the University of Virginia before coming to UNC-CH. Burnett has been teaching at Wake Medical Center as a clinical assistant professor in the UNC-CH School of Medicine since 1975. Cohen comes from the Medical College of Wisconsin where

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he was a corneal-external disease fellow. Lane has been a fellow at the University of Pennsylvania Medical School. King has been a visiting assistant professor since 1976. He also was a postdoctoral fellow at the medical school in 1974-76.

#### News Notes from the—

### DUKE UNIVERSITY MEDICAL CENTER

Radiologists from throughout the United States and Canada convened in Bermuda in October for a radiology postgraduate course, in which members of the Department of Radiology faculty presented scientific sessions covering current concepts in diagnostic radiology, including ultrasound and CT scanning.

Dr. Charles E. Putman, professor and chairman of radiology, was chairman. Dr. Robert McLelland, associate professor, was program director.

Other Duke radiologists serving on the seminar faculty were Drs. Melvyn T. Korobkin, professor; Salutario Martinez, assistant professor; and William M. Thompson, associate professor.

Dr. Jeffrey J. Collins, assistant professor of surgery and microbiology and immunology, presented a workshop paper entitled "Passive Serum Immunotherapy Directed against Friend Leukemia Virus Structural Antigens" during the Inter-National Cancer Congress in October in Buenos Aires, Argentina.

The paper's co-author is Dr. Fred Sanfilippo, a resident in pathology.

\* \* \*

Dr. Harold J. Harris, associate professor in the Division of Child Psychiatry, has received an award for outstanding service to children.

The award, given in observance of the International Year of the Child, was presented by members of the Bahai faith at a Universal Children's Day meeting held in the Durham County Health Center.

\* \* \*

The first 10 years of Duke's experience with a radically redesigned curriculum for its school of medicine is the subject of a book just published by Duke University Press.

The book, entitled "Undergraduate Medical Education and the Elective System," is a series of articles by 34 current or former medical center faculty mem-

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bers describing how the new curriculum came into being and how it worked in training physicians during the years from 1966 to 1975.

Dr. James F. Gifford Jr., associate professor of community and family medicine, served as editor for the 243-page volume.

Supervising editors were Dr. William G. Anlyan, vice president for health affairs, Dr. Ewald W. Busse, dean of medical and allied health education, and Busse's predecessor, the late Dr. Thomas D. Kinney.

\* \* \*

Dr. David C. Sabiston Jr., James B. Duke Professor and chairman of the Department of Surgery, has received a Distinguished Alumnus Award from the University of North Carolina at Chapel Hill.

\* \* \*

Dr. Lennart Fagraeus, assistant professor of anesthesiology participated in a meeting in Luxembourg in October on "Medical Aspects of Diving Accidents."

The meeting, part of an ongoing dialogue concerning the treatment of divers on the oil rigs in the North Sea, was jointly sponsored by the Commission of European Communities (Common Market) and the European Undersea Biomedical Society.

Fagraeus presented a new treatment procedure for severe cases of decompression sickness after air diving that has been developed in the F. G. Hall Laboratory for Environmental Research (hyperbaric chamber) at Duke.

\* \* \*

Dr. Nicholas G. Georgiade, professor and chief of the Division of Plastic and Maxillofacial Surgery, addressed the Kentucky Medical Association in October on "Breast Reconstruction" and "Craniofacial Birth Defects and their Surgical Correction."

Georgiade also addressed the American College of Surgeons during an October meeting in San Francisco on "Total Body Contouring."

\* \* \*

Dr. Robert B. Jennings, professor and chairman of the Department of Pathology, spoke on "Effect of Beta Adrenergic Blockage on Acute Myocardial Ischemic Injury" during an International Symposium on "Modulation of Sympathetic Tone in the Treatment of Cardiovascular Diseases." The symposium was held in Manila, Philippines, in September.

At the VIII World Congress of Cardiology, later in the month in Tokyo, Jennings spoke on "Pathologic Evidence that Infarct Size Can Be Limited."

\* \* \*

Two promotions and two appointments to full professor at the medical center have been made.

Promoted in the Department of Obstetrics and Gynecology and the Department of Anesthesiology, respectively, were Drs. Stanley A. Gall and Bruno J. Urban.

Dr. E. Ralph Heinz has been appointed professor of radiology, and Dr. David G. Shand has been named professor of pharmacology.

\* \* \*

The central teaching laboratory in the School of Medicine has been renamed and dedicated to a man associated with Duke from his student days.

It is now called the Thomas D. Kinney Central Teaching Laboratory. Kinney earned his M.D. at Duke and returned to chair the Department of Pathology from 1960-74. He also was dean of medical and allied health education from 1969-74 and associate provost of the university in 1973-74. He died in 1977.

#### News Notes from the—

### EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE

Dr. C. Lewis Ravaris has been appointed professor and vice chairman in the Department of Psychiatry. In addition to directing the department's residency training program, he will coordinate the department's research activities, primarily in the area of diagnosis and treatment of depression, his special field of interest.

The author of numerous publications, he is responsible for the development of prolixin enanthate and decanoate, long-acting drugs used in the treatment of psychotic conditions.

Prior to joining ECU, Ravaris was associate professor of psychiatry at the University of Vermont College of Medicine.

Ravaris earned his undergraduate degree from Boston University. He received his Ph.D. in physiology from McGill University, Montreal, and his M.D. from the University of British Columbia, Vancouver. He completed postgraduate training at the University of Vermont and Henry Ford Hospital.

\* \* \*

Dr. L. E. Masters has been appointed associate chairman for research and associate professor in the ECU Department of Family Practice.

As associate chairman Masters will direct the department's research activities, primarily in the area of practice management, health care systems and epidemiology. He will also be responsible for developing a computer system to assist in the management of research interests and postgraduate medical education.

Masters has developed computer programs for studying the morbidity, age, sex and practice profile of physicians and residents involved in medical practice. He also has designed medical audit and computer finance systems for use in private practice.

He has been director of family practice residency programs at Iowa Lutheran Hospital, Des Moines



Iowa, and St. Vincent's Medical Center, Jacksonville, Florida. He has held faculty appointments in family practice at the University of Florida and the University of Iowa.

A charter diplomate of the American Board of Family Practice, Masters received his M.D. from the University of Miami and completed postgraduate training at Duval Medical Center, Jacksonville, Florida.

\* \* \*

Dr. Charles E. Boklage, a developmental geneticist, has joined the ECU Department of Microbiology as an assistant professor.

Boklage has done extensive research on genetics, cell biology and developmental biology. He is responsible for developing a new approach to the study of identical and fraternal twins which focuses on the developmental biology of the twinning process and related non-genetic differences.

Prior to joining the medical school, Boklage was completing postdoctoral studies in medical genetics, neurobiology and biostatistics at UNC-CH. He received his undergraduate degree from Bellarmine College and his Ph.D. from the University of California, San Diego.

\* \* \*

Two departments at the ECU School of Medicine presented programs at the American Medical Association Regional Meeting Oct. 21-22 in Asheville.

The Department of Psychiatry presented the "Use of Psychotropic Drugs and Depression." Dr. James L. Mathis, chairman of the department, and Drs. Charles L. Ravaris and William R. Walker directed the discussion.

A session on "Office Gynecology" was presented by the Department of Obstetrics and Gynecology by department chairman Dr. Robert G. Brame and Dr. D. E. Darnell Jones.

\* \* \*

The ECU Department of Microbiology sponsored two conferences on anaerobic infections Nov. 1 and 2. The program included the American Society of Microbiology's Traveling Workshop on "The Fundamentals of Anaerobic Bacteriology as Related to the Clinical Laboratory."

Medical school faculty members participating in the conferences included Dr. Robert G. Brame, chairman of the Department of Obstetrics and Gynecology, and Dr. Robert Fulghum, associate professor of microbiology.

#### AMERICAN SOCIETY OF OPHTHALMOLOGIC AND OTOLARYNGOLOGIC ALLERGY

Walter Ward, M.D., of Winston-Salem was chosen resident-elect of the American Society of Ophthalmologic and Otolaryngologic Allergy at a meeting of the society in Las Vegas. Other new officers are Lueston King, M.D., of Coral Gables, Fla., president,

and William P. King, M.D., of Corpus Christi, Texas, secretary-treasurer.

#### NORTH CAROLINA HEART ASSOCIATION

The North Carolina Heart Association has set a deadline of January 15 for receiving applications for research grants-in-aid up to \$5,000. Grants-in-aid are awarded by the association and its chapters to encourage postdoctoral scientists toward careers in cardiovascular research. They are one phase of the Heart Association's research program which is supported by public contributions to the annual Heart Fund campaign.

Applications for the grants may be forwarded to Lloyd R. Yonce, Ph.D., Chairman, Research Review Subcommittee, North Carolina Heart Association, P.O. Box 2408, Chapel Hill, N.C. 27514.

The North Carolina program is separate from that of the American Heart Association, which annually makes numerous research grants to scientists within the state. Those interested in inquiring about the national program should write to the American Heart Association.

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# Month In Washington

After a bizarre forty-eight-hour swan song, the 95th Congress frantically adjourned leaving dead most of the Carter Administration's major health proposals.

The leading casualty among the health bills was a hospital cost containment measure. Unexpectedly gaining Senate passage in a watered-down version late in the session, the Administration and its congressional leadership pulled out all stops to get it through the House. But strong opposition by a number of House members and the concerted effort of the American Medical Association, the American Hospital Association, and other health groups kept the President's much wanted measure from passage.

The rebuff to the Administration was a victory for health care providers, including the AMA, and was especially sweet to the nation's hospitals which had been subject to bitter criticism by Health, Education and Welfare Secretary Joseph Califano. "Obese," "lazy," "bloated" were adjectives hurled at the hospitals by Califano, who also called the Voluntary Effort (VE) to bring down hospitals' costs a "sham."

Also left in the rubbish on the Hill were the Child Health Assessment Program, clinical laboratory regulations, drug law reform, and a rewrite of the health planning law, the latter gaining a second one-year extension.

Senator Herman Talmadge's (D-Ga.) carefully worked plan to reshape Medicare-Medicaid reimbursement for hospitals through prospective reimbursement also received the ax in the rush for adjournment.

Two provisions sought by the AMA also failed when the bills to which they were attached became mired. One of these would have repealed section 227 of the Social Security Act placing a limit on the reimbursement of teaching physicians. Approved by the Senate as a part of the Hospital Cost Containment Bill, it was never attached to another measure after the hospital bill was doomed in the House. Another AMA-backed initiative would have amended the Professional Standards Review Organization (PSRO) law to protect PSRO data from disclosure under the Freedom of Information Act. The Senate did not get around to this provision which was made part of a Medicaid assistance bill that died because of time limitations.

The \$56 billion appropriations bill for the Labor and Health, Education and Welfare Departments passed after adoption of a compromise covering federal funding for Medicaid abortions. The Health Services

Bill containing authorizations for many public health service programs such as mental retardation and teenage pregnancy did clear the Congress. A provision for aid to hospitals to set up primary care centers was reduced to a demonstration program while the Health Maintenance Organization program was extended, but with less money than the Administration sought. Aid for biomedical research also was approved and the bill sent to President Carter.

An angry confrontation took place on Capitol Hill between the AMA and supporters of Sen. Edward M. Kennedy's (D-Mass.) proposal for national health insurance (NHI). The AMA charged that the Kennedy-Labor scheme for NHI would bring about total federal domination of health care in this country.

"We do not find such a program to be in the interest of the citizens of this country," said James Sammons, M.D., executive vice president of the AMA.

William Felch, M.D., chairman of the AMA's Council on Legislation told Kennedy:

"The total federal takeover of the health care system is inescapable under this program. We do not think the American public will want its health care directed and controlled by the federal government. The history of federally run programs does not instill such trust and confidence as to support such action."

The confrontation took place before Kennedy's Senate Human Resources Subcommittee on Health on the second day hearings on the outline of a new NHI plan proposed by Kennedy. At the opening session, Kennedy heard from six people from Canada who had severe medical problems and from six Americans. He contrasted the high out-of-pocket costs to the Americans with the total government payment of the costs in Canada, declaring that "if these differences between the United States and Canada don't move the people of this nation, then nothing can. . . ."

The hearing was described by Kennedy as "the first serious congressional debate on national health insurance. It will last for many months. It will be carried to every part of this nation."

Dr. Felch noted that Kennedy's plan would impose strict controls through revenue and expenditure limits on hospitals and revenue limits on physicians.

"Manifest is the inherent unfairness of subjecting one industry to stringent cost controls without controlling factors that affect costs in that industry," said Dr. Felch.

"Again, it is grossly inequitable to single out a seg-



ment of our society and economy for discriminatory controls. This on its face would be objectionable."

The heart of the Kennedy-Labor proposal sets national, area and state maximum budget levels of expenditures for health care. Hospital budgets and physician fee schedules would be negotiated annually.

This budgeting process would be controlled through new federal agency called the "Public Authority."

The attempt is to make the health system learn to live within a budget, Dr. Felch said. "The inescapable result of such a budget is 'rationing' of health care," he warned.

"We agree that health care costs must be kept in reasonable balance, but we urge the Congress not to fall into the 'cost containment trap' — the belief that cost control is more important than the alleviation of human misery and suffering."

Dr. Sammons told Kennedy that the AMA shares the concern of proponents of NHI proposals that health care should be available to all persons. He pointed out that the AMA developed a bill in the 95th Congress — the Comprehensive Health Care Insurance Act — that provides comprehensive and catastrophic coverage for all persons. "Its foundation is solidly based upon the successes of our entire health delivery system, allowing for future development and innovation," Dr. Sammons said.

The AMA official testified that since NHI debate began a number of significant changes have taken

place in the health system: a marked increase in numbers of medical schools and medical graduates; a substantial increase in training of allied personnel; proliferation of medical facilities; development of sophisticated technology; wider distribution of medical personnel; expansion of government supported health programs; increased access to care by the disadvantaged; and wider coverage by private health insurance, including catastrophic coverage.

When the senator took issue with Dr. Sammons' statement that Kennedy's bill would result in a total federal takeover, the AMA witness suggested that Kennedy read his bill again.

Kennedy also complained about the AMA's assertion his bill would lead to rationing of health care. Dr. Sammons replied that when fixed budgets and ceilings are established and demand increases, some people will not receive adequate medical services.

Dr. Sammons told the subcommittee that while there are drawbacks in U.S. health care, it is "superior to any other in the world."

\* \* \*

The rupture between the Carter Administration and organized labor on NHI goes unrepaired.

HEW Secretary Califano refused to accede to Labor's demands that the administration tailor its NHI plan to Labor's scheme. The critical difference is Labor's insistence that NHI be implemented in one

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fell swoop; the Administration wants it done in stages.

Califano earlier told the Senate Human Resources Subcommittee that "the President believes that a program this complex — affecting the nation's third largest industry which employs six percent of the entire work force and having profound implications for federal, state, and local budgets — must be phased in with singular care and sensitivity to the economy, governmental budget and the administrative complexity of the health care system."

Califano also indicated the Labor-Kennedy plan would be too costly, pointing to the \$30.8 billion addition to the federal budget by 1983 contemplated by the plan, a figure soft-pedaled by the Labor forces. "We all want the costs of a national health plan to be 'tolerable', but the American people obviously must know specifics before they can reach a conclusion," said Califano.

\* \* \*

The Voluntary Effort has received support from two high Carter Administration officials. During a meeting of the National Steering Committee on Voluntary Cost Containment in Washington, D.C., Barry Bosworth, chairman of the Council on Wage and Price Stability, and Robert Strauss, special counsel to the President, said that President Carter "wanted us to come here today to encourage you in your efforts to contain health care costs." Although the administra-

tion failed to obtain enactment of hospital cost containment legislation, Strauss said the administration recognizes the significant progress of voluntary programs in the fight against inflation.

Bosworth said both he and Strauss were "eager to work with the VE on a cooperative basis." Hospitals are "one of the very few industries in which deceleration (of the rate of inflation) has succeeded," Bosworth said, "and this is significant considering the rate of inflation in the rest of the economy." He added that "the design of the Voluntary Effort addresses the unique problems of its own field better than any other industry the Council on Wage and Price Stability has seen."

Bosworth recommended strengthening the VE by screening the performance of individual hospitals taking into account local differences. He added, however, "the program would be more effective with teeth behind it" in the form of standby controls.

Following the steering committee meeting, Paul Earle, executive director of the VE, announced at a press conference that the rate of growth in hospital expenditures during the first seven months of the year was 12.8 percent — the lowest rate since 1974. "The decrease in the rate of increase in hospital expenditures by 2.8 percent (from 1977) indicates a trend which shows that the VE goal of a two percent reduction will definitely be achieved this year," Earle said.

James Sammons, M.D., executive vice president of the AMA, told those at the press conference that the medical profession is totally committed to the VE outside as well as inside of hospitals. Physicians have been reducing the rate of escalation of fees, Dr. Sammons said, noting that many medical societies have established commissions on the cost of medical care. "A call for moderation in the rate of physicians' fees by Tom E. Nesbitt, M.D., AMA president, has been widely supported," he noted. Dr. Nesbitt was commended by the VE committee for his effort.

Dr. Sammons said the AMA has been meeting corporate leaders to discuss cost factors in health care provisions and noted that the AMA has just issued a cost containment kit to its constituent medical societies.

Alexander McMahon, president of the American Hospital Association; and Michael Bromberg, executive director of the Federation of American Hospitals predicted that the new Congress will be even more resistant to federal hospital control proposals because of the success of the VE.

"The success of the Voluntary Effort in containing hospital costs was the single most important factor in winning Congress' support in the fight against any form of the administration's proposed hospital revenue caps," said McMahon.

\* \* \*

President Carter has singled out the health care sector for special attention in his new wage-price plan to dampen inflation. While calling for the economy as a whole to "decelerate" wages and prices by one half

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percent, the chief executive said the increase of medical care costs should drop by two percent per year.

"The most important step we can take (for medical care) is to pass our bill to control hospital costs," Carter said in his nationwide address. Noting that the Senate this year passed a version of the controversial hospital cost containment program, Carter said "next year I will try again, and I believe the whole Congress will act to hold down hospital costs — if your own members of Congress hear from you. . . ."

In a White Paper on the anti-inflation program, Carter said that "voluntary actions of the medical care industry have moderated the rate of medical care inflation." He was referring to the Voluntary Effort led by the AMA, AHA and the FAH which has succeeded in bringing hospital rate of increase down more than two percent compared with the rate a year ago.

Carter said the White House Council on Wage and Price Stability "will continue to monitor inflation in his sector and will assist the industry's own efforts to contain health care costs. However, the best way to decrease medical care inflation is to enact cost containment legislation."

Carter said "the most significant action we can take to reduce inflation in medical care costs is to institute direct controls over hospital costs."

"A deceleration of only one half percent in medical care costs is not commensurate with the magnitude of these recent cost increases," according to the chief executive.

He said the health care industry "is not one in which market forces can be expected to provide an adequate restraint on price increases."

The American Medical Association applauded

President Carter's call for voluntary controls on wage and price standards as part of his new anti-inflation program. "However," said James H. Sammons, M.D. executive vice president of the AMA, in assessing President Carter's remarks, "we are sorry that the President chose to single out the health care industry, and particularly hospitals, for mandatory controls at a time when that industry has been cited by his own Council on Wage and Price Stability as 'one of the very few industries in which deceleration has succeeded.'"

\* \* \*

The supply of physicians will be more than adequate to meet the nation's needs by 1990, according to a government study.

Tremendous increases in health manpower supply (may) bring supply and demand for most health professions more nearly into balance than at any time in our recent history. The report on the Status of Health Professions Personnel in the United States, prepared by the Department of HEW, suggested the increases stem from the sharp expansion of training facilities and enrollments during the past decade due in part to federal programs to aid medical education.

The numbers of practitioners in the major health professions — medicine (including osteopathy), dentistry, optometry, pharmacy, podiatry and veterinary medicine — are expected to increase from 40% to 70% between 1975 and 1990. In every discipline the supply is expected to increase faster than the population. Physician supply is expected to rise from 379,000 in 1975 to almost 600,000 in 1990 and the ratio of physicians to population from 177 per 100,000 people to 241 per 100,000.

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C—Correspondence	DP—Dean's Page	EMS—Emergency Medical Services
CT—Current Therapy	ED—Editorial	SA—Special Article

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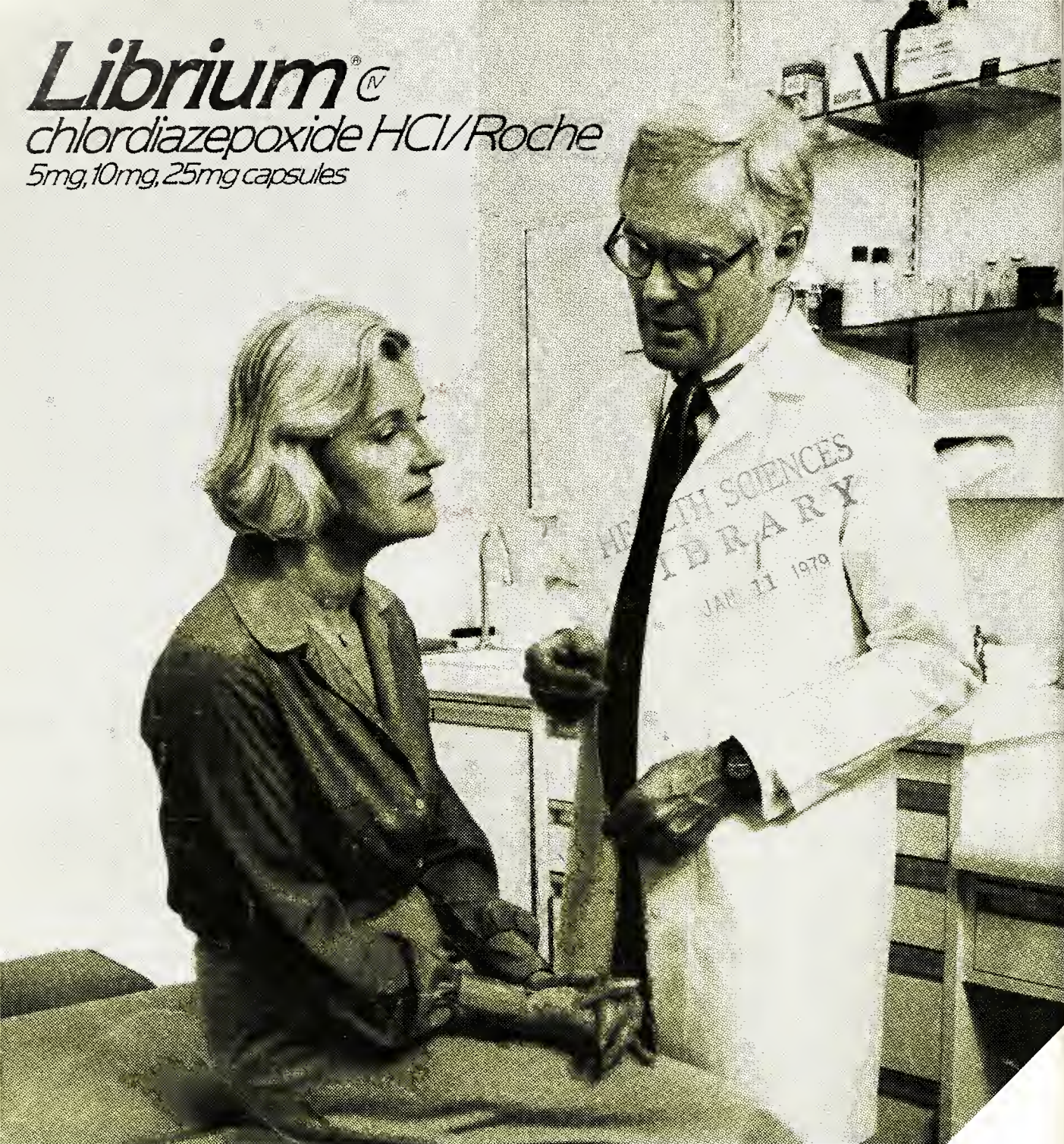
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One Hundred Twenty-Fourth Annual Session  
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May 4-7, 1978

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Briefed and Abridged by  
William N. Hilliard, Executive Director  
North Carolina Medical Society  
222 North Person Street, Raleigh, North Carolina 27611





# NORTH CAROLINA MEDICAL SOCIETY

## TRANSACTIONS

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<i>Vice-Speaker</i> .....	Henry J. Carr, Jr., M.D., 603 Beamon Street, Clinton 28333
<i>Past-President</i> .....	E. Harvey Estes, Jr., M.D., Duke Univ. Med. Ctr., Box 2914, Durham 27710
<i>Executive Director</i> .....	William N. Hilliard, 222 N. Person Street, Raleigh 27601

**COUNCILORS AND VICE-COUNCILORS—1978-1979**

<i>First District:</i>	Edward B. Eadie, Jr., M.D., 1142 N. Road Street, Elizabeth City 27909 (1980)
<i>Vice-Councilor:</i>	William A. Hoggard, Jr., M.D., 1142 N. Road St., Elizabeth City 27909 (1980)
<i>Second District:</i>	Charles P. Nicholson, Jr., M.D., 3108 Arendell St., Morehead City 28557 (1979)
<i>Vice-Councilor:</i>	J. Elliott Dixon, M.D., 215 E. 2nd Street, Ayden 28513 (1979)
<i>Third District:</i>	E. Thomas Marshburn, Jr., M.D., 3208 Oleander Drive, Wilmington 28401 (1979)
<i>Vice-Councilor:</i>	Charles M. Hicks, M.D., 1914 Glen Meade Road, Wilmington 28401 (1979)
<i>Fourth District:</i>	Robert H. Shackelford, M.D., P.O. Box 649, Mount Olive 28365 (1980)
<i>Vice-Councilor:</i>	Lawrence M. Cutchin, Jr., M.D., P.O. Box 40, Tarboro 27886 (1980)
<i>Fifth District:</i>	Bruce B. Blackmon, M.D., P.O. Box 8, Buies Creek 27506 (1981)
<i>Vice-Councilor:</i>	Giles L. Cloninger, Jr., M.D., Box 151, Hamlet 28345 (1981)
<i>Sixth District:</i>	W. Beverly Tucker, M.D., Ruin Creek Road, Henderson 27536 (1980)
<i>Vice-Councilor:</i>	C. Glenn Pickard, Jr., M.D., N.C. Memorial Hospital, Chapel Hill (1980)
<i>Seventh District:</i>	J. Dewey Dorsett, Jr., M.D., 1851 E. Third Street, Charlotte 28204 (1981)
<i>Vice-Councilor:</i>	James B. Greenwood, Jr., M.D., 4101 Central Avenue, Charlotte 28205 (1981)
<i>Eighth District:</i>	Ernest B. Spangler, M.D., Drawer X3, Greensboro 27402 (1979)
<i>Vice-Councilor:</i>	Shahane R. Taylor, Jr., M.D., 348 N. Elm Street, Greensboro 27408 (1979)
<i>Ninth District:</i>	Jack C. Evans, M.D., 244 Fairview Drive, Lexington 27292 (1979)
<i>Vice-Councilor:</i>	Benjamin W. Goodman, M.D., 24 2nd Avenue, W., Hickory 28601 (1979)
<i>Tenth District:</i>	Charles T. McCullough, Jr., M.D., Bone & Joint Clin., Doctors Dr., Asheville 28801 (1981)
<i>Vice-Councilor:</i>	W. Otis Duck, M.D., Drawer F, Mars Hill 28754 (1981)

**DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION**

JAMES E. DAVIS, M.D., 1200 Broad Street, Durham 27705—2 year term (January 1, 1979-December 31, 1980)
JOHN GLASSON, M.D., 306 S. Gregson St., Durham 27701—2 year term (January 1, 1979-December 31, 1980)
DAVID G. WELTON, M.D., 3535 Randolph Road, Charlotte 28211—2 year term (January 1, 1978-December 31, 1979)
FRANK R. REYNOLDS, M.D., 1613 Dock St., Wilmington 28401—2 year term (January 1, 1979-December 31, 1980)
LOUIS DES. SHAFFNER, M.D., Bowman Gray, Winston-Salem 27103—2 year term (January 1, 1978-December 31, 1979)

**ALTERNATES TO THE AMERICAN MEDICAL ASSOCIATION**

GEORGE G. GILBERT, M.D., 1 Doctors Park, Asheville 28801—2 year term (January 1, 1977-December 31, 1978)
E. HARVEY ESTES, JR., M.D., Duke Univ. Medical Ctr., Durham 27710—2 year term (January 1, 1979-December 31, 1980)
CHARLES W. STYRON, M.D., 615 St. Mary's St., Raleigh 27605—2 year term (January 1, 1978-December 31, 1979)
D. E. WARD, JR., M.D., 2604 N. Elm St., Lumberton 28358—2 year term (January 1, 1978-December 31, 1979)
JESSE CALDWELL, JR., M.D., 114 W. 3rd Ave., Gastonia 28052—2 year term (January 1, 1979-December 31, 1980)
M. FRANK SOHMER, JR., M.D., 2240 Cloverdale Avenue, Ste. 88, Winston-Salem 27103—2 year term (January 1, 1979-December 31, 1980)

†Deceased — Albert Stewart, Jr., M.D. succeeded to First Vice-Presidency



## SECTION CHAIRMEN—1978-1979

*Anesthesiology*: David Brown, M.D., Route 4, Box 416, Chapel Hill 27514  
*Dermatology*: Wade G. Rhoades, M.D., 2240 Cloverdale Ave., Winston-Salem 27103  
*Emergency Medicine*: John W. Baker, M.D., 2415 Tanglewood, Charlotte 28211  
*Family Practice*: Lyndon K. Jordan, M.D., P.O. Box 760, Smithfield 27577  
*Internal Medicine*: Alfred L. Ferguson, M.D., Doctors Park, Bldg. 6, Greenville 27834  
*Neurological Surgery*: Robert L. Timmons, M.D., 1709 W. Sixth St., Greenville 27834  
*Neurology & Psychiatry*: Fred Huntley Allen, M.D., 1900 Brunswick Ave., Charlotte 28207  
*Nuclear Medicine*: Robert J. Cowan, M.D., Bowman Gray, Winston-Salem 27103  
*Obstetrics & Gynecology*: John A. Kirkland, Wilson Clinic, Wilson 27893  
*Ophthalmology*: Maurice B. Landers, III, M.D., Duke Univ. Med. Ctr., Box 3802, Durham 27710  
*Orthopaedics*: John A. Powers, M.D., 1500 Elizabeth Avenue, Charlotte 28204  
*Otolaryngology & Maxillofacial Surgery*: Ellison F. Edwards, M.D., 3535 Randolph Rd., Charlotte 28211  
*Pathology*: Charles L. Wells, M.D., Cape Fear Hospital, P.O. Box 2000, Fayetteville 28302  
*Pediatrics*: David R. Williams, M.D., Southgate Shopping Center, Thomasville 27360  
*Plastic & Reconstructive Surgery*: Abner G. Bevin, Jr., M.D., UNC School of Medicine, Division of Plastic Surgery, Chapel Hill 27514  
*Public Health & Education*: Harry T. Phillips, M.D., UNC School of Public Health, Chapel Hill 27514  
*Radiology*: Robert L. Green, M.D., 3155 Maplewood Avenue, Winston-Salem 27103  
*Surgery*: Lockert B. Mason, M.D., New Hanover Memorial Hospital, Wilmington 28401  
*Urology*: Thomas L. Griffin, M.D., Carolina Clinic, Inc., Wilson 27893

# 1978

## Compilation of Annual Reports

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## Compilation of Annual Report

### CONSTITUTIONAL SECRETARY

The Constitutional Secretary performed his duties in 1977 before with the aid and guidance of the headquarters staff. No unusual problems were encountered.

Most of the time and energy expended in 1977 was as a member of the Executive Council, AMA Delegation, Chairman of the Arrangements Committee, and as a member of other committees, ex-officio and appointed. Certainly, the Secretary's performance was not brilliant, but hopefully others will view it as adequate.

Jack Hughes, M.D., Constitutional Secretary

### REPORT OF THE EXECUTIVE DIRECTOR

One of the more significant events for the Medical Society during the 1977-78 Society year was the sale of the remaining portion of the Highway 70 property. Financed over a period of several years, all income realized from the sale of the property will be placed in the Society's Operating Reserve Fund with the hope that this Fund can be built up within a few years to an amount equal to one year's operating expense.

A copy of the Auditor's Report is contained in this Compilation of Annual Reports reflecting that all funds and assets of the Society have been properly accounted for on the books of the Society in conformity with generally accepted accounting principles for non-profit organizations. The Audit Report as submitted by A. T. Allen & Company, dated January 13, 1978, stands as a self-explanatory report of my responsibility as Treasurer for the calendar year 1977 and is recommended for your approval.

The Audit Report also reflects the 1977 management of the *North Carolina Medical Journal* and this portion of the Audit Report is offered as a report of the business affairs of the Journal from the Business Manager. There was an increase of 14% in the Local Advertising income of the Journal, but the National Advertising income declined by 5%. The continuation of a National Advertising income decline undoubtedly reflects difficulties within the national sales organization experienced with the State Medical Journal Advertising Bureau. A change in the sales representative for that organization is apparently turning the trend around since the early months of 1978 show a considerable increase over the same period for 1977. Hopefully this trend will continue throughout the remainder of 1978 and into the future.

Membership in the North Carolina Medical Society continued to grow at a steady, if only a moderate, rate during the 1977-78 Society year. On December 31, 1977, the total membership in the State Society stood at 5,143 as compared with 4,979 on that same date for 1976. As of March 1, 1978,

there were 4,537 members of the State Society after taking into account deceased members during the past year and members who have moved out-of-state. On March 1, 1977, by comparison, there were 3,865 members of the State Society. One must recognize that there are a few slow paying members who have not yet paid their 1978 dues, but we hope that the membership figures will continue to reflect the steady growth which the Society has enjoyed over the last several years. All indications certainly seem to point in that direction since the membership level at all dates compared above are well ahead of the comparable dates for the prior year.

American Medical Association membership among members of the State Society stood at 4,149 on December 31, 1977, a slight increase over the AMA membership for 1976. The AMA membership stood at 4,052 on the December 31, 1976 date. March 1, 1978 membership in the AMA totaled 3,700, up slightly from the 1976 membership figure for the same date.

Including student and intern-resident members, approximately 144 new members have already joined the Society this year which represents almost double the number of new members having joined the Society by this same date last year.

All levels of medical organizations need a strong membership now more than ever before. Your support is urgently needed to make non-members aware of the benefits of membership and the importance of strength in numbers in order for the State Society to more adequately represent the medical profession.

Some 16 County Society meetings were attended by a staff member during the year in addition to three District Society meeting attendance. Staff support has been given for three district and a number of other diverse meetings held throughout various parts of the State. A constant and high level of work activity by staff members has continued for most of the year related to the receiving and recording the continuing medical education membership requirement for members of the Society.

Most annual projects and activities of the Society have continued in a manner similar to previous years with staff support. Principle among these have been the Annual Conference on Medical Leadership held February 3-4, 1978 and the Annual Conclave of Committees held September 21-25, 1977. The Leadership Conference in particular was considered to be one of the most outstanding in many years with record attendance on the part of physician members. A very successful Conference on Sports Medicine was held during July 1977, and a Legislative Reception in the Spring of 1977.

Staff members also coordinated and handled the administrative duties of arrangements for the Governor's Conference on the Quality of Life for Our Senior Citizens which

was co-sponsored by the North Carolina Medical Society. More than 1,000 persons attended the conference.

Under the so-called "Project Unity" Medical Society staff members assist several specialty organizations with the administrative responsibilities of their respective organizations and handle printing and distribution of their newsletters and maintain their membership mailing lists. These efforts are considered by all parties to be most rewarding efforts at unifying all medical organizations under the umbrella of unanimity in North Carolina.

In the opinion of the Executive Director, the entire staff has served the Society in a very commendable fashion, frequently beyond the call of duty. The staff stands ready to assist any county or district medical society in local efforts insofar as staff time permits.

The State Medical Society is fortunate in having a capable and energetic staff to assist your Executive Director, all of whom have participated fully and willingly in the various projects assigned to them. In most cases they have been

completely responsible for various activities, but when more than a single staff person was involved they have worked well together as a team.

All of the staff members, along with the secretarial and graphic art representative are capable and loyal to the Medical Society needs. They continue to deserve your support and appreciation.

My special thanks to Mr. Garland Pace as Controller; Mrs. LaRue King, Assistant to the Executive Director and Convention Coordinator; Mr. Gene Lane Sauls, Director of Field Service; Mr. Stuart Shadbolt, Director of Governmental Affairs; as well as to Mr. Michael F. Cates and Mr. Daniel T. Finch both serving as Field Representatives.

In conclusion, please be assured that my efforts will always be directed now and in the future toward what is understood to be in the best interest of the Medical Society. I continue to appreciate the opportunity to serve your Society.

William N. Hilliard, Executive Director



## ACCOUNTANTS' REPORT

## NORTH CAROLINA MEDICAL SOCIETY

Raleigh, North Carolina

For the year 1977

## OFFICERS

E. Harvey Estes, Jr., M.D.	President	Durham
D. E. Ward, Jr., M.D.	President-Elect	Lumberton
Josephine E. Newell, M.D.	First Vice-President	Bailey
R. Bertram Williams, Jr., M.D.	Second Vice-President	Wilmington
Jack Hughes, M.D.	Secretary	Durham
Marvin N. Lymberis, M.D.	Speaker of the House	Charlotte
Henry J. Carr, Jr., M.D.	Vice-Speaker of the House	Clinton
Jesse Caldwell, Jr., M.D.	Past President	Gastonia
William N. Hilliard	Treasurer and Executive Director	Raleigh
T. Tilghman Herring, M.D.	Chairman—Committee on Finance	Wilson

Chairman and Members of the Finance Committee  
North Carolina Medical Society  
Raleigh, North Carolina

Gentlemen:

We have examined the balance sheet of the North Carolina Medical Society, Raleigh, North Carolina at December 31, 1977, and the related statement of fund balances, the statement of revenue and expenses, and the statement of source and application of funds for the year ended December 31, 1977. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying financial statements present fairly the financial position of the North Carolina Medical Society, Raleigh, North Carolina at December 31, 1977, and the results of its operations for the twelve months period ended December 31, 1977, in conformity with generally accepted accounting principles and applied on a basis consistent with that of the preceding year.

Respectfully submitted,

A. T. ALLEN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

Raleigh, North Carolina  
January 13, 1978

**NORTH CAROLINA MEDICAL SOCIETY**  
**Statement of Significant Financial Policies**  
**For the year 1977**

The North Carolina Medical Society is a nonprofit corporation composed of physicians organized to promote the best interest of the medical profession and to assure quality in the delivery of health care.

Membership dues are the primary source of revenues for the Society; however, revenues are obtained from journal advertising, rental receipts on the headquarters facility and other related activities.

The Society operates under an approved annual budgetary accounting system. Data processing is handled on an in-house computer.

The Society maintains a capital fund for holding fixed assets. Fixed assets include land, buildings, and office furniture and fixtures. Fixed assets are currently being depreciated on a straight line basis.

The House of Delegates approved the establishment of an operating reserve account to generate, as funds avail themselves, reserve equivalent to one year of normal operating expenses, consistent with good business principles. The operating reserve fund has now accumulated \$403,409.31, after a five year period.

The Society purchased the IBM System/32 computer, formerly leased from funds provided by the operating reserve fund for \$42,882.32. The operating reserve fund is to be repaid quarterly, over a five year term, at 7 percent interest, from the regular operating budget. During 1977, the operating reserve fund was repaid three quarterly payments which included \$5,524.45 of principal and \$2,155.76 on interest, for a total repayment of \$7,680.21.

On June 7, 1977 approximately 3.64 acres of land on Highway 70 west of Raleigh was sold to B & B Properties. The net sale price was \$56,647.00. \$19,631.00 cash was received and a \$37,016.00 note receivable placed on the books for a term of five years payable annually, at 8 percent interest.

**NORTH CAROLINA MEDICAL SOCIETY**  
**Raleigh, North Carolina**

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**SCHEDULES**

Cash on Hand and in Banks  
 Schedule of Revenue Compared to Budget  
 Schedule of Expenses Compared to Budget

Schedule 1  
 Schedule 2  
 Schedule 3



**NORTH CAROLINA MEDICAL SOCIETY**  
**COMPARATIVE BALANCE SHEET**  
**For the year 1977**  
**(with comparative figures for 1976)**

<b>ASSETS:</b>	<b>1977</b>	<b>1976</b>
<b>CURRENT OPERATING FUND:</b>		
Cash on hand and in banks (Schedule 1) .....	\$ 641,504.33	\$ 624,763.87
U.S. Treasury notes (\$75,000 face value) .....	74,853.25	74,853.25
Accounts receivable—regular .....	7,083.96	5,836.18
Accounts receivable—national advertising .....	2,706.83	3,089.42
Accrued interest receivable .....	3,633.92	1,906.25
Air travel deposit .....	425.00	425.00
Notes receivable on sale of land .....	79,316.00	47,000.00
Prepaid supplies .....	3,378.22	—
Marketable securities:		
First National Bancorp bonds (\$25,000 face value) .....	25,000.00	—
25 Units corporate bond trust (\$25,000 face value) .....	25,432.50	—
<b>TOTAL CURRENT OPERATING FUND .....</b>	<b>\$ 863,334.01</b>	<b>\$ 757,873.97</b>
<b>CAPITAL OR NON-OPERATING FUND:</b>		
Real estate:		
Land—Lane and Person Streets, Raleigh, North Carolina .....	\$ 227,733.90	\$ 227,733.90
Headquarters building, Raleigh, North Carolina .....	1,044,637.56	1,044,637.56
Land—Highway 70 West, Raleigh, North Carolina .....	116,372.92	134,737.66
Office furniture and fixtures .....	137,901.00	87,448.89
Real estate — two houses and lots, Raleigh, North Carolina .....	34,674.40	34,674.40
<b>TOTAL .....</b>	<b>\$1,561,319.78</b>	<b>\$1,529,232.41</b>
LESS: Accumulated Depreciation .....	191,661.70	159,268.25
<b>TOTAL CAPITAL OR NON-OPERATING FUND .....</b>	<b>\$1,369,658.08</b>	<b>\$1,369,964.16</b>
<b>TOTAL ASSETS .....</b>	<b>\$2,232,992.09</b>	<b>\$2,127,838.13</b>
<b>LIABILITIES, RESERVES AND FUND BALANCES</b>	<b>1977</b>	<b>1976</b>
<b>LIABILITIES:</b>		
Accounts payable—trade .....	\$ 16,679.05	\$ 12,738.96
Dues to be refunded .....	7,322.00	4,396.50
Due American Medical Association .....	—	150,450.00
Due county medical associations .....	107,852.00	40,501.00
Due MEDPAC .....	17,820.00	7,730.00
Federal and state income tax withheld .....	2,545.00	2,012.00
Payroll taxes payable .....	113.54	41.79
Option on sale of property .....	2,000.00	1,000.00
<b>TOTAL LIABILITIES .....</b>	<b>\$ 154,331.59</b>	<b>\$ 218,870.25</b>
<b>DEFERRED CREDITS:</b>		
Advance payments on technical exhibit space at convention .....	\$ 4,920.00	\$ 4,980.00
Advance payments on state membership dues .....	275,316.00	80,862.50
Advance rent from tenant on rental income .....	—	477.73
<b>TOTAL DEFERRED CREDITS .....</b>	<b>\$ 280,236.00</b>	<b>\$ 86,320.23</b>
<b>RESERVES:</b>		
Reserve for public education .....	2,088.98	420.00
Reserve for claims review service .....	2,158.36	1,775.13
Reserve for medical education .....	425.64	244.64
Reserve for leadership conference .....	1,370.00	805.00
Reserve for mental health program .....	2,063.85	2,404.95

	1977	1976
Reserve for operating reserve:		
Cash reserve .....	\$324,093.31	\$ 310,381.75
Contingency reserve (notes receivable) .....	79,316.00 \$ 403,409.31	47,000.00 \$ 357,381.7
Reserve for purchase of equipment .....	2,148.88	4,000.0
Reserve for section on OPH .....	382.85	—
<b>TOTAL RESERVES .....</b>	<b>\$ 414,047.87</b>	<b>\$ 367,031.4</b>
<b>FUND BALANCES:</b>		
Current operating fund (Exhibit "B") .....	14,718.55	85,652.0
Capital fund (Exhibit "B") .....	1,369,658.08	1,369,964.1
<b>TOTAL FUND BALANCES .....</b>	<b>\$1,384,376.63</b>	<b>\$1,455,616.1</b>
<b>TOTAL LIABILITIES, RESERVES AND FUND BALANCES .....</b>	<b>\$2,232,992.09</b>	<b>\$2,127,838.1</b>

**EXHIBIT "B"**  
**NORTH CAROLINA MEDICAL SOCIETY**  
**Comparative Statement of Fund Balances**  
**For the year 1977**  
**(with comparative figures for 1976)**

	1977	1976
<b>CURRENT OPERATING FUND:</b>		
Balance—beginning of year .....	\$ 85,652.02	\$ 38,273.6
<b>ADD:</b>		
Net profit from operations (deficit) .....	(66,933.47)	52,132.7
Closed old reserve account .....	—	50.5
	<u>\$ 18,718.55</u>	<u>\$ 90,456.92</u>
<b>LESS:</b>		
Office furniture and equipment transferred to capital fund .....	4,000.00	4,804.90
<b>TOTAL CURRENT OPERATING FUND—TO EXHIBIT "A" .....</b>	<b>\$ 14,718.55</b>	<b>\$ 85,652.02</b>
<b>CAPITAL FUND:</b>		
Balance—beginning of year .....	\$1,369,964.16	\$1,436,228.94
<b>ADD:</b>		
Capital expenditures from current operating fund .....	4,000.00	4,804.90
Capital expenditures from reserve for purchase of equipment .....	3,851.12	—
Capital expenditures from operating reserve (System/32) .....	42,882.32	—
	<u>\$1,420,697.60</u>	<u>\$1,441,033.84</u>
<b>Less:</b>		
Land sold—cost transferred to reserve for operations .....	\$ 18,364.74	\$ 44,434.76
Current year's depreciation .....	32,674.78	26,634.92
	<u>\$ 51,039.52</u>	<u>\$ 71,069.68</u>
<b>TOTAL CAPITAL FUND—TO EXHIBIT "A" .....</b>	<b>\$1,369,658.08</b>	<b>\$1,369,964.16</b>
<b>TOTAL FUND BALANCES—END OF YEAR .....</b>	<b>\$1,384,376.63</b>	<b>\$1,455,616.18</b>



**EXHIBIT "C"**  
**NORTH CAROLINA MEDICAL SOCIETY**  
**Comparative Statement of Revenue and Expenses**  
**For the year 1977**  
**(with comparative figures for 1976)**

**SUMMARY:**

	1977	1976
<b>Total revenue (Schedule 2)</b> .....	\$678,410.77	\$668,156.12
<b>Less expenses (Schedule 3):</b>		
Executive budget .....	\$350,811.11	\$308,569.70
Journal budget .....	99,847.84	89,606.05
Intra-functional activity budget .....	35,139.73	24,763.05
Extra-functional activity budget .....	25,353.80	18,542.89
Public relations budget .....	8,995.17	7,697.86
Annual sessions — convention budget .....	27,211.81	23,259.32
Miscellaneous budget .....	59,225.13	40,044.11
Headquarters facility budget .....	77,738.96	65,166.46
Operating budget reserves .....	65,020.69	43,178.86
	749,344.24	620,828.30
<b>Excess of revenue over expenses (deficit)</b> .....	\$(70,933.47)	\$ 47,327.82
<b>Add capital expenditures from current funds (included above)</b> ..	4,000.00	4,804.90
	\$(66,933.47)	\$ 52,132.72
<b>Net margin from operations (deficit) to Exhibit B</b> .....	\$(66,933.47)	\$ 52,132.72

**EXHIBIT "D"**  
**NORTH CAROLINA MEDICAL SOCIETY**  
**Statement of Source and Application of Funds**  
**For the year 1977**  
**(with comparative figures for 1976)**

	1977	1976
<b>SOURCE OF FUNDS:</b>		
Decrease in working capital (see below) .....	\$ 23,917.07	\$ —
Increase in reserve for claims review service .....	383.23	513.74
Increase in reserve for medical education .....	181.00	15.64
Increase in reserve for leadership conference .....	565.00	617.00
Increase in reserve for public education .....	1,668.98	420.00
Increase in reserve for section on OPH .....	382.85	—
Net margin from operations (see Exhibit "C") .....	—	47,327.82
<b>TOTAL SOURCE OF FUNDS</b> .....	\$ 27,098.13	\$ 48,894.20
<b>APPLICATION OF FUNDS:</b>		
Net deficit from operations (see Exhibit "C") .....	\$ 70,933.47	\$ —
Purchase of fixed assets from reserve for purchase of equipment .....	3,851.12	—
Purchase of computer (System/32) from operating reserve .....	42,882.32	—
Decrease in reserve for mental health program .....	341.10	—
Increase in working capital .....	—	138,507.82
	\$ 118,008.01	\$ 138,507.82
<b>LESS NON-CASH REQUIREMENTS FOR INCREASES IN THE FOLLOWING RESERVE ACCOUNTS:</b>		
Reserve for operating reserve .....	(88,909.88)	(87,613.62)
Reserve for purchase of equipment .....	(2,000.00)	(2,000.00)
<b>TOTAL APPLICATION OF FUNDS</b> .....	\$ 27,098.13	\$ 48,894.20

**CHANGES IN WORKING CAPITAL:****CURRENT OPERATING FUND:**

Increase (Decrease)

Cash on hand and in banks .....	\$ 16,740.46	\$ (55,202.11)
Accounts receivable — regular .....	1,247.78	1,143.81
Accounts receivable — national .....	(382.59)	(1,216.59)
Accrued interest receivable .....	1,727.67	1,906.25
Notes receivable .....	32,316.00	47,000.00
Prepaid supplies .....	3,378.22	(2,227.37)
U.S. Treasury notes .....	—	74,853.25
Marketable securities:		
First National Bancorp bonds .....	25,000.00	—
25 Units corporate bond trust .....	25,432.50	—
Liabilities .....	64,538.66	50,466.81
Deferred credits .....	(193,915.77)	21,783.76
<b>INCREASE (DECREASE) IN WORKING CAPITAL .....</b>	<b>\$ (23,917.07)</b>	<b>\$ 138,507.82</b>

**SCHEDULE—1**  
**NORTH CAROLINA MEDICAL SOCIETY**  
**CASH ON HAND AND IN BANKS (INCLUDING SAVINGS)**  
**December 31, 1977**

**FIRST-CITIZENS BANK & TRUST COMPANY—RALEIGH, N.C.:**

Checking account—Number 12-03-643 .....	\$ 101,679.63	
Savings account—Number 0861010544 .....	414,917.55	
Certificate of deposit—Number 40576-U .....	23,202.93	\$ 539,800.11

**FIRST FEDERAL SAVINGS & LOAN ASSOCIATION—RALEIGH, N.C.:**

Certificate of deposit—Number 1-21-094338 .....		33,515.91
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**CAROLINA FEDERAL SAVINGS & LOAN ASSOCIATION—RALEIGH, N.C.:**

Certificate of deposit—Number 1673 .....		34,438.13
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**RALEIGH SAVINGS & LOAN ASSOCIATION—RALEIGH, N.C.:**

Certificate of deposit—Number 986085-2 .....		33,675.18
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<b>PETTY CASH—OFFICE .....</b>		<b>75.00</b>
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<b>TOTAL .....</b>		<b>\$ 641,504.33</b>
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**SCHEDULE—2**  
**NORTH CAROLINA MEDICAL SOCIETY**  
**SCHEDULE OF REVENUE COMPARED TO BUDGET**  
**For the year 1977**

	Budget Provisions	Actual	Difference Over (Under)
<b>REVENUE:</b>			
Estimated balance January 1, 1977—			
current operating fund (cash surplus) .....	\$ 60,000.00	\$ 85,652.02	\$ 25,652.02
Membership dues — current and prior years .....	480,000.00	487,973.50	7,973.50
Sales of journals and rosters .....	6,500.00	6,878.96	378.96
Revenue unexpected .....	1,000.00	1,302.54	302.54
Sales of technical exhibit space .....	10,500.00	11,870.00	1,370.00
Journal advertising — local .....	10,500.00	14,635.65	4,135.65
Journal advertising — national .....	20,500.00	15,435.11	(5,064.89)
Commissions (1%) from AMA for dues collected .....	8,000.00	8,024.20	24.20
Commissions (1%) from MEDPAC for dues collected .....	300.00	383.00	83.00
Rental income — headquarters facility .....	55,000.00	42,154.15	(12,845.85)
Rental income — residential property .....	3,000.00	3,802.08	802.08



	Budget Provisions	Actual	Difference Over (Under)
Interest income — operating funds .....	9,500.00	12,939.38	3,439.38
Interest income — on notes receivable .....	—	5,346.67	5,346.67
Interest income — on reserve funds .....	18,000.00	21,391.76	3,391.76
Reimbursements for headquarters office services .....	6,000.00	7,231.76	1,231.76
Sales — Medicine in North Carolina .....	—	375.00	375.00
Sales — relative value studies .....	—	384.75	384.75
Sale of land — gain on sale (\$56,647.00 less \$18,364.74) .....	—	38,282.26	38,282.26
<b>TOTAL REVENUE</b> .....	<b>\$ 688,800.00</b>	<b>\$ 764,062.79</b>	<b>\$ 75,262.79</b>

**LESS CURRENT OPERATING FUND (CASH SURPLUS)**

**JANUARY 1, 1977 (BUDGETED NON-REVENUE FOR 1977)** .....

**TOTAL REVENUE (ACTUAL)** .....

**Executive budget:**

A- 1 President's expense .....	\$ 8,500.00	\$ 5,683.28	\$ (2,816.72)
A- 2 President's secretarial assistance .....	5,000.00	2,500.00	(2,500.00)
A- 3 Travel—secretary .....	1,000.00	1,144.00	144.00
A- 4 Salary—executive director—treasurer .....	39,200.00	39,200.00	—
A- 5 Travel—executive director—treasurer .....	6,500.00	7,790.73	1,290.73
A- 6 Executive office—secretarial and clerical assistance .....	73,000.00	72,344.80	(655.20)
A- 7 Executive office—equipment and replacements .....	4,000.00	4,000.00	—
A- 7a Reserve for future equipment replacements .....	2,000.00	2,000.00	—
A- 8 Expenses—executive office .....	30,000.00	28,684.52	(1,315.48)
A- 9 Bonding .....	255.00	301.00	46.00
A-10 Auditing (quarterly and annual) .....	3,200.00	3,087.27	(112.73)
A-11 Taxes (salary tax) .....	11,000.00	12,062.49	1,062.49
A-12 Insurance .....	2,300.00	2,232.97	(67.03)
A-13 Membership record system and machine rental .....	12,000.00	11,425.39	(574.61)
A-14 Publications, reports and executive aids .....	350.00	429.38	79.38
A-17 Salary—assistant to executive director .....	21,638.00	21,638.00	—
A-18 Salary—field representative .....	12,600.00	12,600.00	—
A-19 Salary—field representative .....	11,000.00	11,000.00	—
A-20 Travel—director, field services .....	3,000.00	3,323.97	323.97
A-21 Travel—director, governmental affairs .....	2,000.00	2,613.54	613.54
A-22 Salary—controller .....	23,945.00	23,945.00	—
A-23 Salary—director, field services .....	20,917.00	20,917.00	—
A-24 Salary—director, governmental affairs .....	18,753.00	16,558.00	(2,195.00)
A-25 Travel—field representatives .....	5,000.00	2,120.13	(2,879.87)
A-30 Retirement system .....	31,500.00	30,568.97	(931.03)
A-31 NCMS headquarters staff hospitalization .....	4,835.00	4,960.46	125.46
A-32 System/32 payments .....	—	5,524.45	5,524.45
A-33 System/32 interest .....	—	2,155.76	2,155.76
<b>Total executive budget</b> .....	<b>\$ 353,493.00</b>	<b>\$ 350,811.11</b>	<b>\$ (2,681.89)</b>

**Journal budget:**

B- 1 Publication of journal .....	\$ 65,000.00	\$ 75,968.81	\$ 10,968.81
B- 5 Expenses—editorial office .....	550.00	522.88	(27.12)
B- 6 Expenses—business manager's office .....	925.00	656.97	(268.03)
B- 7 Equipment—business manager's office .....	100.00	—	(100.00)
B- 8 Travel for journal .....	100.00	—	(100.00)
B- 9 Payroll taxes .....	1,225.00	1,318.83	93.83
B-10 Sales tax on journal and roster sales .....	2,500.00	3,020.35	520.35
B-11 Journal salaries .....	21,200.00	18,360.00	(2,840.00)
<b>Total journal budget</b> .....	<b>\$ 91,600.00</b>	<b>\$ 99,847.84</b>	<b>\$ 8,247.84</b>

	Budget Provisions	Actual	Difference Over (Under)	
<b>Intra-functional activity budget:</b>				
C- 1 Executive council .....	\$ 5,300.00	\$ 5,540.90	\$ 240.90	F-10
C- 2 Publication council minutes .....	6,000.00	5,500.66	(499.34)	F-11
C- 3 Legislative committees .....	6,500.00	9,881.98	3,381.98	F-12
C- 4 Maternal health committee .....	300.00	300.00	—	F-13
C- 5 Drug abuse committee .....	C-11			F-14
C- 7 Scientific exhibits committee .....	1,980.00	1,971.00	(9.00)	F-15
C- 8 Mental health committee .....	C-11			F-16
C- 9 Mediation committee .....	3,000.00	1,833.55	(1,166.45)	total ann
C-11 Committees in general .....	5,000.00	4,280.50	(719.50)	
C-13 Occupational and environmental health committee .....	500.00	—	(500.00)	
C-17 Student AMA committee .....	2,875.00	2,545.29	(329.71)	miscellan
C-18 Disaster emergency medical care committee .....	C-11			G- 1
C-20 Constitution and by-laws committee .....	1,500.00	1,755.12	255.12	G- 2
C-24 Anesthesia study committee .....	398.00	362.32	(35.68)	G- 3
C-30 Liaison to insurance industry committee .....	C-11			G- 4
C-31 Community health committee .....	800.00	439.20	(360.80)	G- 6
C-36 Family marriage counseling committee .....	C-11			G- 7
C-37 Medicine and religion committee .....	200.00	268.48	68.48	G-10
C-49 Medical education committee .....	500.00	110.10	(389.90)	G-11
C-50 Comprehensive health service planning committee .....	C-62			G-12
C-51 Medical aspects of sports committee .....	1,000.00	300.63	(699.37)	G-13
C-53 Physicians on nursing committee .....	C-11			G-15
C-56 President's visitation program .....	—	—	—	G-16
C-59 Health care delivery committee .....	—	—	—	G-17
C-61 Audio-visual program committee .....	200.00	50.00	(150.00)	total mi
C-62 Health planning and development committee .....	500.00	—	(500.00)	headqua
<b>Total intra-functional activity budget .....</b>	<b>\$ 36,553.00</b>	<b>\$ 35,139.73</b>	<b>\$ (1,413.27)</b>	M- 5
<b>Extra-functional activity budget:</b>				
D- 1 Delegates to AMA .....	\$18,350.00	\$17,220.89	\$(1,129.11)	M- 6
D- 2 Conference dues .....	250.00	247.50	(2.50)	M- 7
D- 3 Woman's auxiliary .....	5,400.00	5,400.00	—	M- 8
D- 5 President's Communications (newsletter) .....	3,000.00	2,485.41	(514.59)	M- 9
<b>Total extra-functional activity budget .....</b>	<b>27,000.00</b>	<b>25,353.80</b>	<b>(1,646.20)</b>	M-10
<b>Public relations budget:</b>				
E- 3 Committee chairman, out of state travel .....	\$ 500.00	\$ 361.78	\$ (138.22)	M-12
E- 9 Audio-visual .....	100.00	16.08	(83.92)	M-13
E-10 Educational distributions—materials .....	300.00	984.52	684.52	total be
E-11 News and press releases .....	300.00	402.00	102.00	Operatio
E-12 Public relations bulletin .....	5,500.00	5,288.64	(211.36)	Alloc
E-13 State high school science fair program .....	160.00	200.00	40.00	R- 1
E-15 Medical leadership conference .....	1,600.00	1,680.17	80.17	R- 2
E-17 American medical news subscription .....	300.00	—	(300.00)	R- 3
E-18 Collateral public relations .....	1,000.00	61.98	(938.02)	R- 4
E-19 N.C. rescue squad first aid trophies .....	200.00	—	(200.00)	R- 5
<b>Total public relations budget .....</b>	<b>\$ 9,960.00</b>	<b>\$ 8,995.17</b>	<b>\$ (964.83)</b>	Total
<b>Annual sessions convention budget:</b>				
F- 1 Program production .....	\$ 3,300.00	\$ 3,354.97	\$ 54.97	Total ex
F- 2 Hotel and auditorium expense .....	6,800.00	7,867.31	1,067.31	
F- 3 Publicity promotion .....	200.00	85.00	(115.00)	
F- 4 Entertainment .....	1,400.00	1,462.57	62.57	
F- 5 Orchestra and floor entertainment .....	1,500.00	850.00	(650.00)	
F- 6 Guest speakers .....	2,500.00	3,368.41	868.41	
F- 9 Booth installation and supplies .....	5,000.00	5,279.00	279.00	



	Budget Provisions	Actual	Difference Over (Under)
F-10 Projection expense .....	800.00	559.10	(240.90)
F-11 Badges .....	300.00	296.65	(3.35)
F-12 Transactions reporting service .....	3,000.00	1,838.53	(1,161.47)
F-13 Rental—extra facilities .....	200.00	182.69	(17.31)
F-14 Exhibitors entertainment .....	1,000.00	1,396.20	396.20
F-15 Floral expense .....	300.00	438.88	138.88
F-16 Police security .....	300.00	232.50	(67.50)
<b>Total annual sessions convention budget .....</b>	<b>\$ 26,600.00</b>	<b>\$ 27,211.81</b>	<b>\$ 611.81</b>
<b>Miscellaneous budget:</b>			
G- 1 Legal counsel retainer .....	\$ 26,000.00	\$ 35,482.65	\$ 9,482.65
G- 2 Reporting (executive council, etc.) .....	2,500.00	2,139.02	(360.98)
G- 3 Fifty year club (pins, etc.) .....	600.00	596.09	(3.91)
G- 4 Contingency and emergency .....	13,594.00	12,663.93	(930.07)
G- 6 Ad valorem taxes .....	3,100.00	2,096.18	(1,003.82)
G- 7 Association of professions .....	200.00	200.00	—
G-10 Expense of commissioners .....	1,500.00	1,569.75	69.75
G-11 Expenses of executive committees .....	300.00	—	(300.00)
G-12 Expenses of officers to national meetings .....	2,000.00	182.31	(1,817.69)
G-13 Travel and maintenance, expense of essential staff— out of state sessions .....	2,500.00	1,778.29	(721.71)
G-15 Other property taxes and insurance .....	700.00	676.65	(23.35)
G-16 Residential property repairs .....	1,200.00	840.26	(359.74)
G-17 Contribution to MEDPAC educational fund .....	1,000.00	1,000.00	—
<b>Total miscellaneous budget .....</b>	<b>\$ 55,194.00</b>	<b>\$ 59,225.13</b>	<b>\$ 4,031.13</b>
<b>Headquarters facility budget:</b>			
M- 5 Utilities .....	\$ 25,000.00	\$ 32,137.06	\$ 7,137.06
M- 6 Insurance .....	1,800.00	1,838.00	38.00
M- 7 Taxes .....	16,500.00	16,238.55	(261.45)
M- 8 Water .....	800.00	656.39	(143.61)
M- 9 Janitorial services .....	14,000.00	11,904.50	(2,095.50)
M-10 Grounds maintenance .....	1,800.00	1,436.88	(363.12)
M-11 Building repairs and maintenance .....	4,500.00	4,823.14	323.14
M-12 Heating, air conditioner repairs and maintenance .....	6,000.00	5,575.83	(424.17)
M-13 Extraordinary lessor expenses .....	—	3,128.61	3,128.61
<b>Total headquarters facility budget .....</b>	<b>\$ 70,400.00</b>	<b>\$ 77,738.96</b>	<b>\$ 7,338.96</b>
<b>Operating budget reserves:</b>			
(Allocations to operating reserve fund)			
R- 1 Interest on notes receivable—property .....	\$ —	\$ 5,346.67	\$ 5,346.67
R- 2 Interest on reserve fund .....	18,000.00	21,391.76	3,391.76
R- 3 Extra dues for reserve fund .....	—	—	—
R- 4 Five percent of operating budget .....	—	—	—
R- 5 Gain from sale of land .....	—	38,282.26	38,282.26
<b>Total operating budget reserves .....</b>	<b>\$ 18,000.00</b>	<b>\$ 65,020.69</b>	<b>\$ 47,020.69</b>
<b>Total expenses .....</b>	<b>\$ 688,800.00</b>	<b>\$ 749,344.24</b>	<b>\$ 60,544.24</b>

## AUXILIARY PRESIDENT

As the Auxiliary year of 1977-1978 draws to a close it is with deep appreciation to the North Carolina Medical Society; to the Society President, Dr. E. Harvey Estes, Jr.; and to the Auxiliary Advisor, Dr. Rose Pully, that we make this report.

Using the theme, "TOTAL HEALTH FOR THE TOTAL FAMILY," the Auxiliary has endeavored to become the connecting link between our physician spouses and the communities in which they serve.

Our goals for the year have been three-fold: 1. to continue with on-going programs and projects in health education, 2. to "reach-out" to every age group in the community from "the cradle to the grave" and to provide for them mentally, physically, socially, and spiritually and 3. to seek to provide programs for the "enrichment of medical marriages."

These goals have been accomplished by members of "long standing" and the younger physician spouses, bringing with them much enthusiasm and many new ideas.

Realizing that the more we train the better we serve, the Auxiliary began its year with a "Communications Workshop" at the state convention with the editor of our AMA-Auxiliary, Mrs. Paul Savegeot, as our special guest. Others serving on a panel with her were Jim Burns from TV 6, Wilmington; Elizabeth Rhodes from the *Charlotte Observer*; Mrs. Adrienne Ivey, from the *Roanoke Rapids Newspaper* and the two *Tarheel Tandem* editors, Sara Jo Blair, and Anne Hubbard.

PUBLICATIONS that have been beneficial in communicating this year have been the Auxiliary page in the *North Carolina Medical Journal*; the *Guideposts*, our state workbook which is provided for the 84 members of the Auxiliary board, 50 county presidents and presidents-elect several members of the NCMS; and the Society Headquarters; Direct Line.

Realizing also that the state auxiliary is a link between the AMA-Auxiliary and the county auxiliaries, we have taken advantage of every opportunity for workshops, program materials, on-site visits from AMA-Auxiliary Representatives, and periodicals to train leaders for better service in their communities.

WORKSHOPS AND CONVENTION: A full quota of 9 delegates, the presidential delegate, and 6 alternates attended the AMA-Auxiliary convention in San Francisco. Nine county-presidents-elect joined the state president and president-elect for CONFLUENCE in October in Chicago. Each one reported on the eight seminars at Mid-Winter Leadership Conference in February in Raleigh. These were: "On Being a Woman," Mrs. James Tarrt; "Volunteer Services for the Aging," Mrs. William Owens; "The Family Unit — Shifting Values," Mrs. Robert Cooper; "Techniques for Speakers," Mrs. John Henderson; "The Impaired Physician," Mrs. Parke Davis; "School Health Education," Mrs. Edward Carr; "Television — Education on Positive Viewing," Mrs. Donald Chamblee, and "Parliamentary Procedure," Mrs. Emerson Scarborough. Mrs. Jack Koontz introduced "Confluence" and presided for this program.

For further training at the "grass-roots" level the state auxiliary provided two regional workshops for the ten districts. One was held at Wrightsville Beach and the other in Greensboro. Both were well attended despite the September hurricane which developed that week. Special emphasis was given "Medicine and Religion" with Dr. Archie McKee and Dr. John Grier speaking. Another feature was the International Health Film, "GOLDEN BANGLADESH," featuring a Wilmington native, Dr. Herbert Coddington, who

works with the Bengali physicians. Monies received during the year will purchase saris (native dress for women) which will be distributed at the clinic.

MEMBERSHIP: To increase our membership the Auxiliary encourages every physician's spouse to join our unique organization . . . one must be married to a physician before membership is granted. We encourage county auxiliaries to enlist disinterested members, younger members, and especially our widows. This year we are hoping to reach 3,000 members for AMA-Auxiliary and 3,050 state members. We realize that at this writing (February 15) we must continue with this emphasis and promote our membership theme: "WE CAN DO MORE TOGETHER." Our membership so far is 2,566 (state) and 2,459 (AMA-Auxiliary). They also are members of their county auxiliary.

AMA-ERF: The American Medical Association-Education Research Foundation continues to be the only philanthropic endeavor sponsored by the AMA-Auxiliary. North Carolina Auxiliary with your help (your contributions to your medical school) through our AMA-ERF chairman, Mrs. Paul O'Brien, has reached an all-time high of \$19,379.75. By the end of the year we hope to have between \$20,000 to \$25,000. Our Christmas-sharing cards brings a large amount of this total. At state Convention checks will be given to our medical schools: Bowman-Gray, Duke, East Carolina, and the University of North Carolina.

STUDENT LOAN FUND: This is a service project of the state Auxiliary. Seventy-one loans totalling \$41,561.75 are currently out. No loan is overdue. In re-paying their loans two physicians in recent years sent a contribution with their last payment, showing their appreciation to the auxiliary for the loan to them as students.

SANATORIA BEDS: Happy Birthday! You are celebrating your "Golden Birthday" this year. A \$42,000 endowment supports four sanatoria beds. Each county auxiliary sends monthly remembrances to the patients in the beds.

MENTAL HEALTH RESEARCH ENDOWMENT: This fund is a paid up endowment at \$20,700. The interest from this fund goes to the Department of Psychiatry at the University of North Carolina at Chapel Hill as an unrestricted fund.

LEGISLATION AND AMPAC/MEDPAC: The Auxiliary takes an active roll in working with Mr. Stuart Shadbolt at the Headquarters. Both Auxiliary and Society members work diligently to encourage membership in AMPAC/MEDPAC in order that we might support candidates sympathetic to the cause of medicine.

FILM BANK: This project is only two years old but the two films, "The Heimlich Maneuver" and "New Pulse of Life" are in constant use.

HISTORIES: It is gratifying to learn of the research, compiling, printing, and digging (literally in Cumberland County) in order to keep medical histories up to date. In celebrating the 125th birthday of the Cumberland County Medical Society the local auxiliary is restoring the private cemetery belonging to the first doctor and his family in the county, Dr. Benjamin Robinson, founder of the Society.

Several Counties are completing and printing their county histories. New Hanover-Pender-Brunswick auxiliary will publish the Medical History of the Lower Cape Fear from the 1700's to the present day. Other county auxiliaries who have printed histories in the past are updating them.

COMMUNITY HEALTH: Programs that have been promoted on the county level this year have been: Alcohol and Drug Abuse, Health Careers, Pre-natal care, GENS (good emergency mothers substitute or baby-sitting); Venereal Disease, Mental Health, "Breast Cancer — Self



Examination, Surgery, and Rehabilitation"; Operation Santa Claus" with gifts to O'Berry, Dorothea Dix, Hospitals; nursing home, etc.; Enrichment for Medical Marriages; the AMA Immunization program, scholarships for students in allied health career programs; "Widow and Family Assistance Program"; bloodmobile; "Physical fitness and giving blood to save a life"; CPR and "The Heimlich Maneuver"; Training children in TV viewing; Establishing "sick room" at High School.

**HEALTH MANPOWER:** Untold volunteer hours have been spent by members of our Auxiliaries across the state as they work in Health Museums; Health Fairs; Health Career Fairs; Bloodmobiles; screening programs for children; Hospital chapels and Libraries; follow-up work with 5th graders in 145 grades after they went through the Health Museum; painting walls and pictures to improve Pediatric wards or waiting areas for families; providing sleeper-chairs for parents; Helping with Medical Symposiums; gathering clothes for a Blind Orphanage in Bogota, Columbia, So. America; cancer clinics; working with the aging; Having life-saving program at Malls and other public places; working with retarded children and learning-to-read programs for children, Foreign people, and illiterates; radio and TV health program; the Lung Society; Heart Fund; HOSTS (Help One Student To Succeed); bicycle and "clean the closet" safety programs; and many, many others.

To make money for their projects the Auxiliaries have Benefit Concerts, Celebrity Series, Arts In the Park, Antique shows, Silent Auctions, luncheons for the Society meetings, Etc.

**DOCTOR'S DAY:** For several years North Carolina has won the Best State-wide Observance of Doctor's Day and Best Exhibit awards at SMA-Auxiliary convention or both. This past year your president and Councilor, Mrs. James Gibson, along with a past president of AMA-Auxiliary, Mrs. C. T. Wilkinson, and Mrs. Baxter Troutman who was elected president-elect for this next year represented the J.C. Auxiliary. First place Award was given this year to North Carolina for the Best State-Wide Observance.

**HEALTH EDUCATION:** Immediate past president, Mrs. Edwin Martinat, continues to work with her committee

in trying to get appropriations for Health Bill #540 in order that North Carolina might have health education taught in every school from K through High School using trained teachers.

This year we have been most fortunate to work with Dr. Estes, Mr. Bill Hilliard, Mrs. LaRue King, Mr. Dan Finch, Mr. Mike Cates, and the other staff members at the Society's Headquarters as we participated in the Communications Workshop provided for and by Burroughs-Wellcome the day before our Mid-Winter-Leadership conference. We feel that this is a step in the right direction as we work to become a program extension arm of the Society. Our deep appreciation to Dr. John McCain who has included the Auxiliary for several years on the planning committee for Communications workshops.

I am most grateful for Dr. Estes' program several years ago at a Symposium and again two years ago when he spoke to the Auxiliary on "The Fifteen Years Syndrome." From this thoughts one of our goals this year, "Enrichment For Medical Marriages," was projected. Many auxiliaries have had joint programs with their Societies on this topic. One even took their spouses to a mountain retreat!

If I could take more time and space I still could enumerate many more programs and projects each Auxiliary member is engaged in and as the TV personality said, it would be "Not bragging — just facts."

My Officers, District Councilors, my Advisor, Dr. Pully, Board members, County presidents and presidents-elect have been great to work with and from their reports printed and distributed at Convention you, too, can see it's been a profitable year.

It has been my privilege to attend the AMA Auxiliary in San Francisco; Confluence in Chicago; Southern Medical Association Auxiliary in Dallas; Southern Regional for AMA-Auxiliary in Atlanta; and every District meeting and Auxiliary meeting to which I have been invited.

We, the Auxiliary, pledge to you our very best not only for the rest of this year but next year and the years to come. We are your spouses. Call on us. WE CAN DO MORE TOGETHER.

Mrs. Robert J. Andrews, President

## REPORT OF COUNCILORS

### FIRST MEDICAL DISTRICT

This has been a good year for the physicians in the First Medical District. Eastern EAHEC buildings have been completed in Elizabeth City and Edenton. The members have enjoyed and benefited by the programs presented by EAHEC. Also, the membership was appreciative of Dr. Estes taking the time and effort to come visit us during the summer so that there could be a face to face exchange of ideas and goals.

Communication, both within the District and with the State Society seems to be improving, and we anticipate this to continue to improve. Also, I think of interest to his many friends throughout the state is the fact that Dr. John Payne who suffered a myocardial infarction in August is continuing to steadily improve and has returned to limited practice.

Edward B. Eadie, Jr., M.D., Councilor

### SECOND MEDICAL DISTRICT

The seemingly endless barrage of paperwork and commensurate fees as determined by the various government

bureaucratic agencies has resulted in fewer practitioners in the Second District seeing "stamp holders." The concern expressed in only quiet dialogue is that of what form socialized medicine will be when it is enacted.

A few situations in which announcements were extended in regional media to the point of bordering on advertising were handled to the satisfaction of all concerned.

The physician population is increasing in the District and this is appreciated by all concerned parties.

Except for the intrusion of outside forces, the practice of medicine in the Second District remains very pleasant.

Charles P. Nicholson, Jr., M.D., Councilor

### THIRD MEDICAL DISTRICT

Action of the Third District over the past one year has focused primarily upon reorganization and reactivation of Third District activities. Accordingly, a meeting was held in Kenansville in July of 1977, for purposes of discussing whether or not the Third District should become more active. The consensus was that the District should become

active along political lines. This meeting was attended by Dr. Harvey Estes, President of the North Carolina Medical Society, Mr. William Hilliard, Executive Director of NCMS, and Mr. Gene Sauls, Director of Field Services for North Carolina Medical Society. Twenty-six physicians were present, representing exactly one-tenth of the number of physicians in the Third District. Numerous suggestions for the Third District activities were made and each was thoroughly discussed with seeming enthusiasm.

During the year other visits were made to various county societies, namely, Duplin and Onslow. The topics for discussion concerned physician opposition to the chiropractic and optometrist bills before the State Legislature and determining enthusiasm for reactivation of the Third District Medical Society.

The first meeting of the Third District in eight years will be held March 15, at the Blockade Runner Motor Hotel at Wrightsville Beach with a political program consisting of representatives of the State Medical Society and various state legislators and senators from throughout the Third District. It is hoped that this will be a well received and enthusiastic meeting promoting more active and strenuous participation by physicians along that line.

E. Thomas Marshburn, Jr., M.D., Councilor

#### FOURTH MEDICAL DISTRICT

The Fourth Medical District has operated during the current medical society year with no major problems. No specific disciplinary activities have come to the attention of the councilor. Several members of the Society residing in the district have received life memberships in the North Carolina Medical Society and several other awards have been received.

The annual meeting of the Fourth District was held in October, 1977, and was well attended and no business of note was conducted beyond the election of officers. This has been reported to the headquarters.

The councilor met with President Estes and representatives from headquarters and the legislative committee in Wilson during the fall of 1977 to outline some of the plans and needs of the Medical Society for the coming year. Several county societies were represented at this meeting.

No further Medical Society activities of note occurred in the district during this year.

R. H. Shackelford, M.D., Councilor

#### FIFTH MEDICAL DISTRICT

The Fifth District held its annual district meeting on September 30, 1977 which was a combination social, business and educational meeting which was attended by a very large crowd. Associated with this meeting was a conference held with the members present with Dr. D. E. Ward, President-Elect, in lieu of the regional meetings that were held by Dr. Estes, in that the two meetings were so near one another, they were combined.

Contact with the various County Societies reveal no problems of any magnitude that required any specific action.

Attendance at the Medical Leadership Conference on February 3rd and 4th was attended by several members of the District with excellent response and appreciation for the meeting.

A. M. Oelrich, M.D., Councilor

#### SIXTH MEDICAL DISTRICT

During the past year since our Annual Society Meeting Pinehurst, there has been moderate activity in the Sixth Medical District. At the beginning of the year, we were in course faced with the dilemma of attempting to bring the issue of the chiropractic and optometric bill to the attention of all the members of our district. This was requested by our President and attempts were made to contact the President of various representative county societies in an attempt to influence the legislators as best we could. We have also been in contact with Mr. Hilliard, Mr. Shadbolt and Dr. Estes regarding other legislative matters of concern to all physicians in the state as well as our district. It has been our pleasure during this past year to congratulate several members of our district on achieving life membership in the North Carolina Medical Society as well as recognizing certain members of the 50 Year Club of the North Carolina Medical Society.

The Presidents' visitation program which was held for our district on October 19, 1977, in Durham had an extremely disappointing turnout. Of our some eleven hundred members, only eleven were present for this very important meeting to discuss matters of interest and importance to our local district. We hope that this does not indicate any great degree of apathy on the part of the members of our district but we have been very concerned.

Your Councilor has been active in the local Medical Society but has not had the opportunity to visit other county Medical Society meetings as he had hoped but will attempt to do this in the upcoming year. We of the Sixth Medical District again want to pledge our support to our leaders in Raleigh and to the organization of the North Carolina Medical Society as a whole.

W. Beverly Tucker, M.D., Councilor

#### SEVENTH MEDICAL DISTRICT

(not received as 3-8-78)

#### EIGHTH MEDICAL DISTRICT

The District Councilor attended all the Executive Committee Meetings at Pinehurst. The Councilor responded to all inquiries and requests by the societies within the district. No major problems were encountered within the district during the past year.

Ernest B. Spangler, M.D., Councilor

#### NINTH MEDICAL DISTRICT

By action of the Davie County physicians in February 1977, seven of their members transferred their membership from the Rowan-Davie County Society to the Forsyth County Medical Society. Following this action the Davie County Society requested that they be terminated from the Rowan-Davie County Society and be allowed to affiliate with the Forsyth County Medical Society. This action was supported by the Executive Council of the Society and approved by the House of Delegates at the meeting in May. As a result of this action, Davie County is now removed from the Ninth Medical Councilor's District. On Thursday, October 6, President E. Harvey Estes met with members of the Ninth Medical District in Statesville. Much of the meeting was centered around the discussion of the physician's involvement in the political arena and with the increasing



importance that this area is playing in medicine.

In an effort to assess the need for additional physician's assistant programs which were being developed on two Community College campuses, a meeting was held in Lexington during the year with various representatives from the Medical Society, the teaching institutions, and the two physician's assistant programs involved. Following this a recommendation was made to the Executive Committee Council of the medical staff for consideration. It was the feeling of this group that physician's assistant programs should not be developed at the Community College level and that the expertise of the medical schools was necessary to provide the basic science support for the program. This position was supported by the House of Delegates.

Jack C. Evans, M.D., Councilor

### TENTH MEDICAL DISTRICT

The Tenth District continues to improve its medical community. Asheville hospitals, in particular, have expanded their facilities and now have the expertise to provide care for a wide range of medical and surgical problems. To mention a few:

Whole body C. T. Scanning; Cardiac CATH Lab with full range of services include echocardiography and Holter monitor equipment; Surgical cardiology with a full range of open heart procedures, excepting neonates; Intra-aortic balloon pump; Ultrasound studies; A premature intensive care unit including a transport team; Improved cerebral circulation through anastomosis of deep and superficial circulation; Transphenoidal pituitary and posterior fossa microsurgery; Perinatal laparoscopy, flexible endoscopy with retrograde cholecystography and pancreatography; Hand digital reimplant microsurgery; Vitrectomy, laser photocoagulation, faco-emulsification; Chemodialysis and home dialysis training have been ongoing for several years.

Hospital construction in Western North Carolina recently completed or under construction involves:

Memorial Mission — 45 beds  
Pardee Memorial — 29 beds  
Murphy Hospital — 50 beds  
Haywood County Hospital — 200 beds  
Angel Community Hospital — 73 beds  
Nursing Home construction in Western North Carolina recently completed or under construction involves:

Aston Park — 120 beds  
Asheville Rehab. Nursing Center — 100 beds  
Asheville Convalescent Center — 120 beds  
Abbeyvilla (Hendersonville) — 150 beds

The following breakdown of medical personnel by county is of interest:

COUNTY	ACTIVE RN'S	FAMILY PRACTICE	GENERAL PRACTICE	INTERNAL MEDICINE	GENERAL SURGERY
Haywood	132	9	6	4	6
Buncombe	954	36	9	54	63
Henderson	259	9	9	12	13
Madison	34	4	3	0	0
Transylvania		5	4	4	1
Polk	45	4	3	2	5
Macon	46	4	2	1	1
Cherokee	43	3	3	0	2
Rutherford	166	6	5	4	2

Brevard Intermediate Care Center — 47 beds  
Murphy Medical Center — 120 beds  
Pigeon Valley Center — 60 beds  
Skyland Care Center (Sylva) — 34 beds  
Madison Manor (Morris Hill) — 75 beds  
Swain Nursing Home (Bryson City) — 120 beds

The Mountain Area Health Education Center is fulfilling its mission. Their family practice resident staff now consists of eight first-year, nine second-year, and four third-year residents. Of the four third-year residents, two have made commitments to settle in rural areas within this district. Additional medical students are rotating from Chapel Hill and Winston-Salem through either OB-GYN, Cardiology, or Family Medicine. Allied Health students in physiotherapy, pharmacy, and public health are also rotating through this district for grassroots training.

The Health Sciences Library and Learning Resource Center is supplying inter-library loans, medline and reference question searches. Audio-visual materials have been made available for teaching purposes. A total of 89 audio-visual programs were provided by MAHEC.

The family nurse practitioner training program of 1976 certified 10 nurse practitioners, all of whom are now practicing in Western North Carolina.

The MAHEC education building, a \$2.5 million project was completed in September 1977. This includes a 300 seat lecture hall, 20 faculty and administrative offices, a mix of classrooms which can accommodate groups ranging in size from 12 to 60, and a library with a capacity of 60,000 volumes.

Four hundred thirty-seven continuing education programs have been sponsored by MAHEC from July 1976 through June 1977. Half of these were conducted outside of Buncombe County. Of these 437 programs, 105 involved allied health disciplines, 2 dentistry, 125 medicine, 34 nursing, 16 pharmacy, 27 public health.

The HSA governing board of our area (Area f) consists of 56 members, 10 indirect providers, 15 direct providers, 31 consumers. Of the direct providers, there are 5 physicians serving: Dr. H. A. Matthews, Dr. Thomas E. Reardin, Dr. T. Reginald Harris, Dr. Harry Glenn Buchanan, and Dr. Margery O. Strawn.

Our Annual 10th District "Social" was held in September at the Waynesville Country Club. The weather and Waynesville Medical and Auxiliary staff were most cordial and as usual this affair helped us to become better acquainted.

This Tenth Medical District is a busy, vital, exciting place to live and work. Hopefully, we will channel our energies and profit from the mistakes of our area.

Kenneth E. Cosgrove, M.D., Councilor

### ADMINISTRATION COMMISSION

All committees under the Administrative Commission have carried out their duties well for the year. For details of their activities see under the individual committee reports.

A. Hewitt Rose, Jr., M.D., Chairman

### ADVISORY AND STUDY COMMISSION

The North Carolina Medical Society members who participated in the eight committees that make up the Advisory and Study Commission have been active during the past year. All committees have met at least once and a number of them have had multiple meetings.

**Allied Health Professionals Committee** — reviewed its role, the activities of the Joint Practice Committee and matters of mutual concern to physicians and allied health professionals. There will be efforts at increased liaison between nursing organizations and this committee in order to clarify roles of physician assistants and other allied health professionals. The Joint Practice Committee continues to be very active. Frank M. Mauney, Jr., M.D. chairs this Committee and has had a most active and productive year.

**Anesthesia Study Committee** — is chaired by Albert Arthur Bechtoldt, Jr., M.D. The Committee continues its detailed study and evaluation of anesthetic related deaths in North Carolina.

**Committee Advisory to Auxiliary** — is chaired by Rose Pully, M.D. This Committee benefits greatly from the participation of the Auxiliary. A vigorous, enthusiastic auxiliary participates fully in the Committee activities and deliberations.

**Committee on Cancer** — chaired by Margaret Ann Nelsen, M.D., reports that it plans to be more active in the Central Cancer Registry. The Committee further expresses strong support for the Duke Breast Cancer Demonstration Project and commends Josephine Newell, M.D. for her excellent work on this project. This Committee made the following observations and recommendations to the Department of Human Resources: 1) Physicians be sent a brief description of Department of Human Resources programs and services available to them and their patients

2) Screening for oral cancer and Hemocult testing be continued in Health Department Screening Clinics where personnel are adequately trained, 3) Asymptomatic women who have had two normal annual pap smears should receive a pap smear every two years.

**Committee on Constitution and Bylaws** — is chaired by Dr. Louis deS. Shaffner. Revision updating and amendments to the constitution and bylaws continues to receive proper attention through the nurturing of this document by our constitutional expert and past president.

**Committee on Medical Cost Containment** — chaired by Jesse Meredith, M.D. has been most active in this arena. The following five recommendations to the Legislative Study Commission on Medical Cost Containment have been made. 1) The Legislative Study Commission on Medical Cost Containment investigate a method to provide reimbursement for home custodial care for eligible and suitably approved patients as an alternative to care in an ICF. 2) The Legislative Study Commission on Medical Cost Containment seek financial support from Federal, State or other sources for pilot program to demonstrate the practicality and cost savings from the provisions of financial aid and personal services in the home as an alternative to ICF care. 3) The Legislative Study Commission on Medical Cost Containment examine other state Medicaid programs (such as Virginia) which have successful eligibility determination

programs. 4) The Legislative Study Commission on Medical Cost Containment recommend the development of procedures to permit dual certification of SNF beds to allow re-imbursement for ICF care when such care is the level of care provided. 5) The Legislative Study Commission on Medical Cost Containment recommend establishment of reimbursement structure whereby acute care hospitals would be paid at the SNF or ICF rate in those instances where it is determined that acute care is or was not necessary but SNF or ICF care was needed. Our committee, the committee on Medical Cost Containment, continues to make recommendations on this important subject. Recommendations and activities suitable for County Medical Societies are being prepared and are announced in the Journal or the President's Newsletter.

**Committee Advisory to Medical Students** — In the past has attempted to monitor, encourage, and stimulate student Medical Society activities. Increased Committee activity additional Student Medical Society Members, and a new student chapter at ECU is anticipated during the up-coming year. Results of the Committee's efforts will be evaluated at the end of one year for recommendation for continuing the Committee or its abolishment. This Committee chaired by James A. Bryan M.D. promises to inject new life and vigor into Student Medical Society activities.

**Committee on Traffic Safety** — chaired by George Johnson, M.D. continues to be an active and valuable addition to physicians and the public. The Committee, among its many other activities, has considered the matter of Child Restraints in automobiles. The Executive Council has endorsed the following resolution presented by the Committee on Traffic Safety: The North Carolina Medical Society supports the use of approved automobile Child Restraints for children ages 1 to 5. The Committee continues its indepth support by participation in the Physicians Guide to Medical Education and by furnishing medical advice to the Department of Motor Vehicles.

This brief summary is a "tip of the iceberg" of the many activities during the year. Your Committee members have given generously of their time in support of your Medical Society activities.

T. Reginald Harris, M.D., Chairman

### ANNUAL CONVENTION COMMISSION

There will not be a report for the Annual Convention Commission due to the untimely death of the Commissioner, Oscar L. Sapp, III, M.D., on January 22, 1978.

### PROFESSIONAL SERVICE COMMISSION

The Blue Shield Committee, chaired by Dr. John Foust and Vice-Chairman Dr. Walter Roufail, continues to meet monthly to aid the corporation in developing medical policy and claims adjudication. This Committee does most excellent work for the policy holders of the Blue Cross Corporation as well as the multiple providers of care to these individuals.

Dr. Coonrad continues to chair the Committee of the Medical Society which is advisory to the Crippled Children's Program in North Carolina. The Committee is active and ably lead by Dr. Coonrad with good direction to state government in this important area.

Health Planning and Development Committee, chaired by Henry Nicholson, M.D. of Charlotte continues to monitor the Health Service Agency activities and health planning in



North Carolina. With the increased HEW activities, this is an increasingly important Committee and probably will become much more active.

The Hospital and Profession Relations and Liaison to the North Carolina Hospital Association Committee, chaired by Dr. Bill Fore of Greenville, for the first time, has plans to increase the activities and relationship with the Hospital Association. This Committee will also become increasingly important and active as the health care providers need to join hands to deal with the increasing governmental encroachment.

The Industrial Commission Committee, chaired by Dr. Ernie Spangler continues to serve the North Carolina Industrial Commission in an advisory capacity in a most excellent fashion and aids in claims adjudication, as well as policy matters.

The Insurance Industry Committee, under the able leadership of Chairman, for the past three years, Dr. Charles Duckett, has met four times this year to adjudicate many claims for the private insurance industry. This Committee is most valuable to the professionals in the relationships and claims adjudication with the insurance industry.

Dr. Ed Martinat has chaired the Rehabilitation Medicine Committee for several years and with the increasing number of rehabilitation units in the state, this has become more active and more important, and continues to function well.

The Committee on Social Services Programs, chaired this year for the first time by Dr. Stephen Edwards, Pediatrician from Raleigh, has a broad range of responsibilities. The principle area of concern of course is the Medicaid Program and the Committee had a most excellent meeting in Mid Pines in September and adopted significant resolutions

and program advice for the Society to recommend to the state to aid in improving the Medicaid Program.

I appreciate the opportunity to have served as Chairman of this Commission and to have worked with these excellent committees.

M. Frank Sohmer, Jr., M.D., Chairman

### PUBLIC RELATIONS COMMISSION

Most of the committees in the Public Relations Commission met in Mid Pines during the Conclave in September, 1977. Several of the committees have met since that time. The committees have been unusually busy this year. All of the meetings have been well attended and very productive as indicated by the reports of the committee chairmen listed separately.

Marshall S. Redding, M.D., Chairman

### PUBLIC SERVICE COMMISSION

The meetings of the various committees of the Public Service Commission were under the acting Chairmanship of Rose Pully, M.D. who graciously and very ably took over my position as Chairperson during September. The work of each committee is described in its individual report but perhaps it is appropriate here to stress our gratitude to Dr. Pully for all that she did in our absence and also to the Chairman and members of each committee for their unrelenting enthusiasm and constructive action.

Philip G. Nelson, M.D., Chairman

## REPORT OF COMMITTEES

### COMMITTEE ON ALLIED HEALTH PROFESSIONALS

The Committee on Allied Health Membership was largely comprised of newly appointed Members and a new Chairman was installed in an overall effort to reorganize and redefine the thrust and responsibilities of this Committee in the ever changing environment of the Allied Health Professional Group. An effort was made at the Annual Committee Conclave to review the historical perspective of this Committee and to acquaint all newly appointed Members with many of the political and practical problems which had been presented to the Committee in the past decade.

While this Committee was not directly involved with the debate between the North Carolina Nursing Association and the North Carolina Academy of Physician Assistants concerning Substitute House Bill 1216, it has continued to monitor and offer its support and assistance to the Ad Hoc Committee appointed by President Estes in working out joint recommendations to the legislative committee responsible for any revisions to this bill in 1978.

Dr. Estes has invited Members of the Medical Society to communicate to the Chairman of this Committee any instances of alleged improper utilization or supervision of either Physician Assistants or Nurse Practitioners. Thus far only two minor issues have been raised. Each of these was thoroughly reviewed and in the one instance where there was some misunderstanding, corrective measures were instituted.

Two notices in the President's Newsletter have been sent out and the Committee is pleased to note that only two reports of alleged impropriety have been received, and in

each of these cases it was largely a matter of misunderstanding of role function rather than actual improper practice behavior.

Bryant Paris, Jr., Executive Secretary of the Board of Medical Examiners who is the Liaison to the Committee on Allied Health, reported to us that since the Board of Medical Examiners first established a review process for Physician Assistants in November of 1971, 226 P.A.'s have been approved by the Board with 196 currently registered and active. Since the Nurse Practitioner Program was first established in June, 1974, 176 have been approved by the Board of Medical Examiners and 162 currently are registered with the Board.

Efforts have been made during the past year to further delineate the responsibilities of the Committee on Allied Health with some overlapping responsibilities of the Joint Practice Committee. The Joint Practice Committee is made up of six physicians and six nursing representatives of the North Carolina State Nursing Association. It was formed several years ago for the purpose of bringing together nursing representatives and medical representatives to discuss any matter affecting the interface between these two professional groups. The Chairman of the Committee on Allied Health sits on the Joint Practice Committee and has found this to be an extremely valuable interface for improved liaison in communication between his Committee and the Nurses Association. It offers the only formal mechanism for direct communication at the working committee level.

The future thrust of this Committee will probably center on the expanding role of so-called physician "extenders" in

a variety of categories. It is anticipated by the Chairman that much effort will be required to further disseminate the actual working environment of these categories of Health Professionals, both to the Physician Members of the North Carolina Medical Society and to the health consumer and our nursing allies as well. Close monitoring of the expanding role of the nurse practitioner will also be an increasing responsibility in the next several years as this group is in the midst of national reorganization and further growth and development in a variety of clinical areas.

Finally, in the past year at least one registered nurse opened an independent practice in the State to offer "clients" counselling in various types of nursing practices. While this has been going on in other parts of the Country for several years, it was a new experience for the physicians in this community, many of whom did not know exactly what their legal and interrelated responsibilities would be. Because of this uncertainty the matter was brought before the Joint Practice Committee by the Chairman, Committee on Allied Health, and continuing efforts are being made to develop a position paper and further clarification of just what nursing acts will be offered in this setting.

Frank M. Mauney, Jr., M.D., Chairman

#### COMMITTEE ON ANESTHESIA STUDY

The Committee on Anesthesia Study met at the Mid Pines Club on September 23, 1977. The paper, *Anesthetic Related Deaths, 1969-1975*, which was presented by the Chairman, Dr. Bechtoldt, at the North Carolina Medical Society Annual Meeting in May 1977 was discussed. The statistics on anesthetic related deaths in North Carolina for this six-year period were reviewed and suggestions were made for their incorporation into a paper to be submitted for publication. In order to correlate the number of anesthetics given with the number of anesthetic related deaths, a tabulation of the number of anesthetics given in North Carolina for this six-year period has been started. Every hospital administrator in North Carolina has been contacted, requesting the information, and up to this date, about 70% of the hospitals have replied. Further efforts are being made to gather information from the remaining hospitals so that the final report can be meaningful.

The Committee heard a report on the number of operating room deaths for 1977. Dr. Bechtoldt stated that there were 43 operative deaths, of which 8 were presented to the Committee for discussion of the relationship to anesthesia. In addition, there were 3 post-operative deaths possibly related to anesthesia.

The Medical Examiner participated in 10 of these 11 deaths. The Medical Examiner system has been contributing to this Committee's work, but certain difficulties remain. Dr. Page Hudson plans to correct these difficulties and has requested the Committee's help, and the North Carolina Medical Society's backing.

Another article has been published in the *Bulletin*, and together with individual correspondence to anesthesia departments, standards of anesthesia care in North Carolina should be improving. It is anticipated that the six-year study will point out problem areas more clearly. Hopefully, enough hospitals will complete their reports on anesthetics administered, to make the six-year study meaningful.

Albert A. Bechtoldt, Jr., M.D., Chairman

#### COMMITTEE ON ARRANGEMENTS

With the help of and prodding by other members of the Committee, the results of the Chairman's efforts for the 1978

Annual Meeting should be reasonably rewarding for those attending. The format will be relatively unchanged. Two of our medical schools will again stage the General Session scientific programs. Only the golf tournament will be missing. Declining interest, the hassle about starting times, and the problems over picking winners because of the difference in difficulty in playing the various courses brought about the tournament's demise.

Each year the committee considers other possible meeting sites. Because other facilities cost 5 to 10 times as much and in the absence of membership's overwhelming demand for change, we continue to meet at Pinehurst. But we don't have to.

Jack Hughes, M.D., Chairman

#### COMMITTEE ON AUDIO-VISUAL PROGRAMS

The Committee on Audio-Visual Programs has met and arranged a two-day audio-visual program for presentation at the Annual Meeting of the Society in Pinehurst in May 1978.

There are no action items for the Executive Committee.

Albert Stewart, Jr., M.D., Chairman

#### COMMITTEE ADVISORY TO AUXILIARY

The Committee Advisory to the Auxiliary met September 23, 1977, at Mid Pines Club, Southern Pines, N.C. Mrs. Mary Leila Andrews, President of the Auxiliary gave her report which included:

1) the State Auxiliary theme for the year, "Total Health for the Total Family".

2) Auxiliary membership as 3,032.

3) North Carolina AMA-ERF contributions reached a record high of \$30,223.20, which was distributed to the four medical schools of the state.

Mrs. Mary Jane Means, President-Elect, discussed plans for the 1978 Fall Workshop to be held on September 25 and 26, 1978, at Mid Pines Club.

The Committee requested by motion that the Council on Review and Development consider formulation of a policy that members of the N.C. Medical Society not receive an honorarium for participation in functions of the North Carolina Medical Society and its Auxiliary.

The School Health Bill, HB 540, endorsed by the North Carolina Medical Society and the Auxiliary is in the Appropriation Committee of the North Carolina General Assembly and the Auxiliary Chairman, Mrs. Martha Martinat is working vigorously on behalf of this legislation.

Rose Pully, M.D., Chairman

#### COMMITTEE ON AWARDS

On September 19, 1977, in a telephone conference, with 100% committee members, the Committee reviewed a previous telephone call in which the nature of the Committee and its current objectives were discussed. The Chairman noted again the history of the Committee and the general lack of interest in meeting. Usually only three to five papers were submitted and according to Dr. Sapp no awards had been given for the past two years. Although two papers were submitted from the May 1976 meeting, no awards were given. No papers were available from the 1975 meeting. Three awards are now available: the Moore County Award for best scientific paper, the Wake County Award (Cooper Award) for best paper on preventive medicine and the Durham-Orange County Award for the best paper by a med-



ical student or intern-resident. In the Committee's memory no Durham-Orange Award had been given. (Later Mrs. LaRue A. King stated that one award was given.)

Dr. Walter M. Newton, Jr., President of the Moore County Medical Society said it was his opinion that their county had very little interest in the awards at this time, and many members do not understand the reason for the bill each year. His "horseback" opinion is that this county society had little interest and given an opportunity Moore County Medical Society would withdraw its award. No other action can be taken by the Moore County Society until the next meeting two to three months hence.

Dr. George M. Cooper, Jr., son of Dr. G. M. Cooper, Sr., was contacted. He felt that the family had been very appreciative of the recognition given Dr. Cooper, Sr. and that the initiation of the award many years ago was an important loving memory for them. Dr. Louis Kermon, President of the Wake County Medical Society was then contacted and it was his impression that the award at this time, so many years later, had little significance to the current members of the Wake County Medical Society. Only a few now remember Dr. Cooper and he took it upon himself to talk to Dr. Cooper, Jr. about this matter. He later reported indicating that Dr. Cooper, Jr. understood that since many years had passed the award had lost its significance and that there would be no hard feelings if it were withdrawn. An official action by the Wake County Medical Society. Only a few now remember Dr. Cooper and he took it upon himself to talk to Dr. Cooper.

The general lack of interest by Section Chairmen in the annual meeting was recognized since only two to three papers were usually submitted. The different nature of a speech given at a Medical Society meeting from that of a paper written was also discussed. Mailing the award has come about in order to streamline the annual meeting but has resulted in an unimpressive and very impersonal presentation.

Dr. Sapp referred to minutes of two years ago, 1975, in which the Committee was urged to consider "Awards for Scientific Exhibitors" now covered by the Annual Convention Commission, "Golf and Tennis trophies" expense now covered by the Arrangements Committee, "Special Awards" to Executive Council members at the completion of terms. It was the consensus of the Committee that the Committee on Awards would be dabbling into other committee work and "making work" to get into those efforts i.e., for an Executive Council member who has served unusually long and well, the Executive Council who knows him should recognize his efforts rather than the Committee on Awards. The Committee discussed the feelings that had come about over the last year or two. Dr. Brabson indicated: 1) a general lack of interest, 2) papers from medical schools by interns and resident staff were sent just to present a paper, 3) the Hooper Foundation in honor of Dr. Hooper discontinued its efforts in another area of North Carolina for general lack of interest, and 4) no competition at present for prizes. Also reported was a conversation with a Past President who indicated his impression that the Awards Committee seemed to have no modern function.

A MOTION WAS MADE BY DR. BRABSON, SECONDED BY DR. ROGER E. SMITH and DULY PASSED to the effect that:

THE COMMITTEE CONVEY ITS DISCUSSIONS THROUGH DR. SAPP TO THE APPROPRIATE BODIES, THE COUNCIL ON REVIEW AND DEVELOPMENT, THE EXECUTIVE COUNCIL, AND THE BYLAWS COMMITTEE.

He is to convey the lack of interest, lack of papers, and the

unanimous feeling that the Committee served well many years ago but has little or no function in the modern Medical Society, and that the Committee unanimously urges a change in the Bylaws to abolish the Awards Committee. The MOTION passed unanimously.

Further discussion ensued as to needs if a component society did not withdraw its awards. It was the consensus of the Committee that one big problem is the lack of involvement of the component societies and if the component societies wish to continue its awards it should do so through its own involvement. It was recognized that a future president might appoint such a committee if a need arose at a future date.

**OLD BUSINESS** — The two papers from the 1977 Annual Meeting submitted for consideration were:

"OPERABILITY OF CARCINOMA OF THE ESOPHAGUS" presented by Gordon F. Murray, M.D., UNC School of Medicine, Chapel Hill, before the Second General Session in Pinehurst in May 1977 and selected by the Section on Surgery.

"BREAST CANCER" presented by Hyman Muss, M.D., Bowman Gray School of Medicine, Winston-Salem, before the First General Session in Pinehurst in May 1977 and selected by the Section on Internal Medicine.

DR. GORDON MURRAY'S PAPER WAS NOMINATED AND SELECTED FOR THE MOORE COUNTY AWARD BEST PAPER, AND DR. HYMAN MUSS' PAPER WAS SELECTED FOR THE WAKE COUNTY AWARD.

The Council on Review and Development reviewed the request of the Committee to abolish the Committee on Awards, and recommended to the Executive Council that this be done. Dr. Charles Nicholson made a motion that the Committee on Awards be eliminated. The motion was seconded and passed.

Ernest B. Page, Jr., M.D., Chairman

### COMMITTEE ON BLUE SHIELD

The Blue Shield Committee consists of at least one member representing each major practice specialty appointed by the President of the State Society for one year terms subject to reappointment, except that no member may serve more than five terms in any eight-year period.

It is the duty of the Committee to advise and counsel with the members of the Medical Society on all matters relating to claims or any other business that they may have with Blue Cross and Blue Shield of North Carolina; to inform the physician members of the Corporate Board of Trustees about any matter deemed worthy of consideration and action by that board; and to advise and counsel with representatives of Blue Cross and Blue Shield on any matter of mutual concern.

It is not the duty of the Blue Shield Committee to set professional fees or to tell a physician what he can charge. It is, though, its duty to recommend what is a fair amount for the plan to pay a physician on behalf of its subscribers.

When new procedures, both diagnostic and therapeutic, are introduced, it is not the duty of the Committee to determine they are proven, but it is the duty of the Committee to investigate the validity of those who are proving them and then to recommend a fair payment for these services when justified.

The Committee is empowered to organize itself into subcommittees for claims, review all other activities, and may meet as often as advisable. The whole Committee is required to announce and hold each year at least four open meetings.

during which any member of the Society may present items for consideration by the Committee.

The following meetings have been held during 1977-1978:

Wednesday, August 24, 1977

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

Wednesday, September 21, 1977

2:00 p.m.

Mid Pines Club, Southern Pines

Wednesday, October 26, 1977

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

Wednesday, November 23, 1977

3:00 p.m.

Medical Society Headquarters Office, Raleigh

Wednesday, January 18, 1978

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

Wednesday, February 22, 1978

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

Wednesday, March 22, 1978

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

Wednesday, May 3, 1978

3:00 p.m.

Mid Pines Club, Southern Pines

(May 4-7: Annual Meeting of the North Carolina Medical Society)

Wednesday, June 28, 1978

3:00 p.m. BCBSNC Service Center

Durham-Chapel Hill Boulevard

During this year the Blue Shield Committee has had an attendance averaging approximately 80% at each meeting. This is considered very good considering the nature of physicians' schedules, the distance that many members must travel, and the fact that some of the specialties represented have a small percentage of the total work done by the Committee. I think this attendance reflects the good interest physicians are showing in work that reflects an obligation to the public and accountability of the profession.

During the first six months through December 1977, the Blue Shield Committee:

A. Reviewed 66 claims and recommended settlement.

B. Recommended 38 Blue Shield Index modifications or additions.

C. Considered and recommended action in eight medical considerations involving guidelines for future similar cases.

D. Members of the Committee by phone or mail were consulted approximately 1200 times by Blue Cross and Blue Shield of North Carolina personnel. The formal and informal advice and comments of these Committee members with multispecialty skills were used by Blue Shield to determine equitable allowances in particular cases.

E. Three physicians were referred to the Mediation Committee of the North Carolina Medical Society.

One of the major accomplishments of the Committee during this period was to finalize recommendations for revision of the cardiac catheterization section of the Blue Shield Index so current techniques could be reported and equitable values established. A special Ad Hoc Subcommittee of cardiologists representative of most heart catheterization services met and reported to the Committee their suggestions for terminology and Blue Shield Index values for the procedures described. With minor modifications the terminology describing heart catheterization services listed in the 4th edition of the AMA Current Procedural Terminology was utilized.

The Committee considered recommendations of the Blue Shield Association which had in cooperation with the National Specialty Colleges asked local Blue Shield Plans to look at certain procedures and services which have become obsolete or applicable only for limited conditions. After due consideration by applicable specialty members, the Committee recommended implementation of the program to modernize schedule nomenclature and recommended that benefits for several procedures be limited to conditions for which they are applicable as generally recognized by the medical profession. Any exceptional case can, of course, be individually reviewed by the Committee.

A special multispecialty subcommittee, under Chairmanship of Dr. Edward V. Staab and working in cooperation with North Carolina radiologists, is at this writing perfecting recommended guidelines for payment of Blue Cross and Blue Shield benefits. It is understood that CT Scan data from individual cases will be collected and used as source material for continuing education. The Chairman has appointed the CT Scan Subcommittee on an ongoing basis so the membership representing radiology, neurology, internal medicine, general surgery, and neurosurgery can monitor new technical developments and continue educational efforts for appropriate CT Scan use. The impact of this new technology, both as to capital costs and potential saving through ambulatory service and shortened hospital stay, makes this an important activity for the Committee, the Plan and its subscribers.

I take this opportunity to express appreciation for the able work of the members, and the support of Vice Chairman Dr. Walter M. Roufail and Commission Chairman Dr. Frank Sohmer. The staff and officers of Blue Cross and Blue Shield have been fully cooperative, and your Chairman has met regularly with the Plan Board of Trustees and has reported to the Board the activities of the Committee.

John W. Foust, M.D., Chairman

## COMMITTEE ON CANCER

The first meeting of the year was held June 17, 1977 in the North Carolina Medical Society Building and chaired by Dr. James A. Maher. Due to a lack of quorum, actions taken at this meeting were reviewed at the second meeting on September 22, 1977 held at Southern Pines, chaired by Dr. Margaret A. Nelsen. Actions approved at the September meeting include the approval of three new hospitals- participation in the Diagnosis and Treatment Program of the Division of Health Services of the North Carolina Department of Human Resources.

The Chronic Disease Branch's request to support chemotherapy for eligible post-mastectomy patients was also approved for \$200 per year. A request for increase in this sum was made, however, no final action was taken. This aspect was not resolved at the September meeting due to the committee's lack of cost data for the several modes of chemotherapy currently in use.

Support for treatment of all stages of choriocarcinoma in eligible patients was approved.

Recommendation was made that oral cancer detected by screening programs should be referred to the most expert physician or dentist available locally. Specific problems should be directed to the chairman of this committee.

Guidelines for recommended methodology in testing for occult blood in the stool as screening for occult carcinoma of the gastrointestinal tract were requested in June and rediscussed in September. Recommendation is that either direct random testing be used or a meat free diet preceding the



est be utilized as best suited the local situation. Data from current studies on the best methodology was not available for more specific recommendations. The representatives from the American Cancer Society were asked to report their results on national as well as state studies in this regard for future consideration.

Pre-cancerous cervical conditions evaluated with support from the Department of Human Resources were reported at both meetings. Cost of evaluation per patient at the three medical centers averaged \$70.48 at Bowman Gray, \$74.89 at Duke University and \$73.38 at the University of North Carolina at Chapel Hill clinics. This was less than anticipated and most gratifying. Plans to increase the utilization of this program are underway.

Additionally reported at the September meeting, was the support of 2,040 patients by the Diagnosis and Treatment Program for cancer patient care involving \$1,168,951. The balance of \$66,769 which reverted to the State Treasury regarding this program caused much discussion. A more detailed report has been requested for the future, as the committee felt there are more patients who may qualify if physicians were aware of how to better utilize these resources. A recommendation that this program be made clear and available to physicians was made.

At both meetings, a long discussion regarding a quality of life survey by the Central Cancer Registry ensued. Concern for confidentiality between a patient and their physician was expressed. After lengthy discussions, there was no definite conclusion at either meeting.

At both meetings, a report on the Durham Breast Demonstration Project was presented. This also involves training of nurses to teach patients breast self-examination. As of September, 1977, 96 nurses representing 50 of our 100 counties have completed this training and 8,919 women have been examined and taught breast self-examination with 62% of these women below 35 years. Three hundred and eighteen (318) women have been referred to private physicians for evaluation of breast masses. Four proven cancers have been reported all in the over 50 age range. The committee continues to support this project and commends Dr. Josephine Newell for her excellent work in these activities.

The cancer screening programs of the DHR report stated in June, that from July to December, 1976, 92,916 persons were seen in the cancer screening, pre-natal, multiphasic, family planning and other clinics, the largest age group being under 35 years. Problems in the follow-up and subsequent referral of positive screens have been identified and will be a primary concern of this Committee for the future. A second problem identified at the September meeting, was a back-log of pap smear readings at the state cytology laboratory of 21,000 tests. The committee and Mr. Earl Emory of the State Laboratory are extremely concerned. This back-log apparently is due to technical staff support problems. At the September meeting this was addressed in some detail. A recent report to the American Cancer Society Executive Committee meeting on January 12, 1978 by Dr. Burns Jones confirms that the back-log has been cleared, but apparently cytology technologist staffing continues to be a problem. After much discussion concerning the heavy load of pap smear readings in the state laboratory, it was recommended that any asymptomatic woman who has two normal annual pap smears requires only one pap smear every two years.

Discussed at both meetings was the Governor's Advisory Council on the Cause and Control of Cancer. No new information is available to this committee regarding this advisory group and the committee's consensus is that our increased attention to the above matters is required and general agreement is that increasing communication and input is needed.

Recommendations and reports evolving from the September meeting follow.

Dr. Richard Martin, Mrs. Harriett Flint and Ms. Sheryll Kincaid presented reports from the North Carolina Division of the American Cancer Society and covered the Mecklenburg County screening program, the Reach to Recovery Program (active in 57 counties), the Uterine Task Force Public Education Program and the Anti-Smoking Program in schools (emphasis on Grade 3). Continued help, advice and support of the American Cancer Society, North Carolina Division is much appreciated by this committee.

Dr. Diane McGrath, Director of Cancer Information Service, has sent reports concerning the Cancer Information Service which in 15 months of initial operation received 9,000 calls, with 27 calls average per day. Detailed breakdown of these calls is available and will continue to be provided to this committee.

A report concerning the Cancer Control Workshop held in Greensboro on February 10 and 11, 1977 has also been made available to the committee. A resolution emanating from this workshop concerned insurance coverage for cancer diagnosis and treatment. This topic has been raised before to this Committee and generated much discussion in September. A lack of information regarding what exactly, is and is not, supported by our North Carolina insurance programs hampered any recommendations. A firm commitment to acquire this data and address this problem has been made.

Since the September meeting, several other topics have come under consideration.

The Central Cancer Registry needs stable, active and knowledgeable advisory help. Two hospitals as of January, 1978, may no longer participate and planned upgrading of activities, reports and statistical methodology has been held in abeyance. Problems in the Diagnosis and Treatment Program have arisen specifically regarding potential support for favorable prognosis melanoma patients, as determined by utilization of Clark's level of invasion. Additionally the details of follow-up of suspicious or positive results of screening programs has not been addressed. This Committee will inquire further into these topics.

On December 29, 1977 the Ad Hoc Committee on Unproven Methods of the Treatment of Cancer of the American Cancer Society, North Carolina Division, Inc. first met under the Chairmanship of Dr. John R. Kernodle with membership from the Cancer Committee. It is the intention of this Committee to fully participate in this activity consistent with Resolution 11 of the House of Delegates Annual Meeting of May 7, 1977 and to help coordinate activity of the Communications Program Chairman of the North Carolina Medical Society and the Professional Education Chairman of the American Cancer Society. In May, 1978, a special panel will discuss these issues at the North Carolina Division of the American Cancer Society Executive Committee meeting.

A major activity during the Fall and Winter has been the participation of the Chairman in the State Health Coordinating Council Cancer Task Force. This is a state-wide policy and decision-making body which is to develop a State Health Plan. Each of the 14 Task Forces has been assigned the responsibility of identifying precursors and consequences of the assigned health problem and formulating goals and objectives relative to recommending courses of action. The task of formulating such, even for cancer alone, is enormous. Time and administrative constraints make the task even more formidable.

This Committee was represented at the deliberations by the chairman. Input is not to be equated with either the

committee's approval or the North Carolina State Medical Society's approval, during draft formulation. As of January 18, 1978, the goals and objectives were revised to some extent by state health officials. When the final document is available, it will be presented to the full committee and the Society. The impact and influence of these recommendations may be seen before this. This Committee has to date only an advisory voice in spite of our unique position of approval under G.S. 130-186.

The continued input of concerned Society members is sorely needed. Dr. Maher, the previous chairman, has been of enormous benefit to this Committee and the Society and we all regret the loss of his expertise. Continued support, questions and criticisms from the Society's membership is solicited by the committee and warmly welcomed.

Margaret A. Nelsen, M.D., Chairman

### COMMITTEE ON CHILD HEALTH & INFECTIOUS DISEASES

The Committee met on Friday, September 23, 1977 at eight o'clock P.M. at the Mid Pines Club in Southern Pines, N.C. The following motions were considered and passed by the Committee for submission to our Society's Executive Council:

1. The Committee recommends that routine screening of newborns for hypothyroidism be established as a part of the newborn screening program.

2. The Committee goes on record as strongly supporting the phasing out of lay midwifery in North Carolina.

3. Whereas the North Carolina Medical Society supports the goal of excellent medical care for all patients and, whereas, many physicians are discouraged from seeing Medicaid patients because of the low rate of reimbursement and, whereas, Medicaid recipients generally require more time than other patients in a practice and, whereas, Federal guidelines allow a fee of 100% of the 75th percentile, therefore, be it resolved that the Committee on Child Health recommends that the North Carolina Medical Society support the payment of 100% of the 75th percentile based on the previous twelve months data.

Immunization requirements and immunization status in our State was discussed. It was reported that the most recently completed survey of two-year olds revealed that 82% had completed their immunization requirements. This is encouraging and better than the national average. It was stressed that continued effort should be made by all physicians caring for children to insure that adequate immunization status is completed and maintained.

William L. London, M.D., Chairman

### COMMITTEE ON CHRONIC ILLNESS

The Committee on Chronic Illness met during the September 1977 Committee Conclave and outlined the functions and goals of the committee. Among the items considered by the members was a report by Dr. Burns Jones, Division of Health Services, on the statewide screening as well as the diagnostic and treatment programs sponsored by the Division.

The committee continues to review these and other health screening programs of the Division of Health Services.

J. Dewey Dorsett, Jr., M.D., Chairman

### COMMITTEE ON COMMUNICATIONS

I. PROBLEM: In the communications media, the distorted reporting of deaths from adverse drug reactions; the implied unnecessary hospital admissions; the rising cost of care being attributed to physicians; the touted frequency of complications and deaths from unnecessary surgery; the much publicized Medicaid and Medicare fraud and abuse accusations, etc., are indicative of the need for an improved public relations program. With the combination of the advent of syndicated investigative medical reporting, the availability of unlimited quantities of computer-generated raw medical data for unskilled analysis, and the implementation of the Freedom of Information Act, a bleak communications outlook can be anticipated for organized medicine collectively and for each physician individually.

II. NEW COMMUNICATIONS PROGRAM ADOPTED: In May, 1975, the North Carolina Medical Society House of Delegates, and in May, 1976, in the exaugural remarks by then President Jim Davis, an enhanced public relations program was requested. Presidents Jesse Caldwell and E. Harvey Estes supported these requests. A much expanded communications program was adopted by the May 1977 House of Delegates with supportive funds from a pro-rata share of a membership dues increase.

III. NEW COMMUNICATIONS PROGRAM IMPLEMENTED

A. The name of the committee was changed from the "Committee on Public Relations" to the "Committee on Communications."

B. A weekly series of articles on health topics, "Health Watch," is being sent to newspapers in North Carolina. Dan Finch is the editor of this service, provided under the supervision of the Health Education Subcommittee. Don Chaplin, M.D., Assad Meymandi, M.D., Elizabeth Kanof, M.D., and others have assisted in preparing some of the articles.

C. The Health Education Subcommittee, chaired by Elizabeth Kanof, M.D., has initiated a program to provide appropriate responses to favorable and unfavorable news articles about medicine. Medical specialty section chairmen are serving as resource consultants for the subcommittee. Physicians are asked to send in newspaper clippings or respond to newspapers themselves. This "over-see" function by the subcommittee provides assurance that health news reporters are held accountable for their actions. A protest to the director of the UNC-TV Network in Chapel Hill was made for the UNC-TV Network showing a program entitled, "Health Care: Your Money or Your Life, You Can't Have Both." This TV program was very misleading to the public. The opportunity of a response was requested and granted. The AMA has been asked to assist in the preparation of a TV response.

A nationally prominent chain drug store was questioned about the production and distribution of a movie on generic medications that was misleading to the public. This movie was removed from distribution. The subcommittee also assisted the Committee on Medical Cost Containment in the preparation of a proposed brochure on cost containment that is to be distributed to the public.

D. A program was initiated to take health information to the public by physicians participating in local TV and radio talk shows under sponsorship of communications committees of county medical societies. A Communications Training Seminar was held on 2-3-78 at Burroughs Wellcome Headquarters Building in the Research Triangle Park to encourage physician participation in radio and television talk shows. In response to leadership by Mrs. Mary Leila Andrews, Mrs. Virginia Warren, and Mrs. Martha Martinat



auxiliary members agreed to act as agents for county societies and local radio and TV stations to facilitate participation in this type of program. This training seminar was attended by 137 physicians and auxiliary members. Winston Singleton, M.D., Dave Reynolds and other members of the Surrougns Wellcome staff conducted the program. "How-O" booklets prepared by Dave Reynolds were distributed to those in attendance. Follow-up phone calls to each of the counties involved to offer local program assistance, with follow through as needed, is planned to assure maximum acceptance of this new program.

E. A membership survey was conducted to determine the interest of members, their desires, and their suggestions for improving communications. The results of the returns are being presented elsewhere.

F. A Governor's Conference on the Quality of Life for Our Senior Citizens was held in Raleigh at Meredith College on July 6 & 7, 1977. The conference was cosponsored by the North Carolina Medical Society and attracted 950 persons. The committee commended Clem Lucas, M.D., who chaired the conference, and the headquarters staff, William Hilliard and Mike Cates in particular, for the fine work performed in making this one of the "finest programs ever held in the nation" . . . an evaluation by Senator Frank Church, speaker at the conference. A quality of Life Conference for Middle Years of the family is planned to follow.

#### IV. NEW COMMUNICATIONS PROGRAM PLANNED

A. In May a project is to be initiated in which weekly five minute tapes on health topics are to be prepared and distributed to participating radio stations in North Carolina.

B. Informal receptions for health reporters of the communications media are planned to allow us to know and work more effectively with them.

C. County medical societies are to be encouraged to hold NCMS-press dinners to encourage cooperation with the local media representatives.

D. An executive secretary conference is planned (for full or part-time employees or others) to determine how the NCMS can help them better serve their members.

V. CONFERENCE FOR MEDICAL LEADERSHIP: A Conference for Medical Leadership was held at the Sheraton Crabtree in Raleigh February 3-4, 1978 in memory of Dr. Edgar T. Beddingfield. For the first time the meeting was co-hosted with NCMS and Auxiliary Councilors and Vice-Councilors. The personal involvement of these NCMS and Auxiliary decision-makers helped to make this one of the best attended (total 270 with 135 M.D.s) and most enthusiastically received conferences that we have ever held. As an additional innovation suggested by Dr. Estes, caucuses by the members from each district and by specialty medical society presidents were held Saturday morning preceding an open-discussion luncheon session. An excellent job was performed by the entire headquarters staff, Mr. Dan Finch in particular, in promoting and conducting the conference.

VI. ENHANCEMENT OF GERIATRIC MEDICAL EDUCATION: A resolution from the committee was approved by the Executive Committee of the NCMS that identified the need for increased teaching and research in geriatrics in North Carolina. This resolution was in follow-up of the Conference on Aging.

VII. NEED FOR KIDNEY DONORS: A joint statement identifying the need for cadaver donors for patients with end-stage renal disease was prepared and accepted by the Executive Council of the NCMS and NCHA. In this statement the importance of leadership from community physicians and hospitals was stressed in order to obtain more

cadaver donors. Mr. Michael Phillips, P.A. from Duke University assisted the committee in this effort.

VIII. ORIENTATION FOR HOUSE OFFICERS: In a statement approved by the Executive Council Bowman Gray School of Medicine was commended for implementing an orientation program for house officers soon-to-enter practice. Other medical schools were urged to sponsor similar practice seminars.

IX. TERMINALLY ILL STATEMENT: The need for a public education statement on the terminally ill, death, and dying was identified to be prepared perhaps in cooperation with the North Carolina Hospital Association, the North Carolina Council of Churches, and others. This statement would be available for family members and patients at times of crisis.

#### X. CONTINUATION OF EXISTING PROGRAMS:

A. A more attractive and less expensive "Newsletter" type of format for the Bulletin, as designed by Dan Finch, was instituted. Guest editorials by elected NCMS officials and brief professional liability insurance hints inserts are to be continued. A new insert, "Committee Spotlight," is to be started in which committees otherwise receiving very little publicity are to be highlighted. Also, articles from the NC Peer Review Foundation are to be carried as space permits.

B. Sponsoring a North Carolina Academy of Science Award is to be continued.

C. The project to give an award to the winner of the North Carolina Rescue Squad first aid competition at their annual meeting is to be also continued.

The committee is deeply indebted to members of the Medical Auxiliary, Mrs. Martha Martinat, Mrs. Mary Leila Andrews, and Mrs. Virginia Warren, for their help in supporting, planning, and implementing the many programs to improve communications.

Appreciation is expressed to members of the committee who are responsible for most of the activities performed; to President E. Harvey Estes who served not only as a leader but a stimulator, facilitator, and supporter, and to Mr. William Hilliard, Mr. Dan Finch, and others of the headquarters staff who have performed behind-the-scene staff support without which the committee could not have functioned.

John L. McCain, M.D., Chairman

#### COMMITTEE ON COMMUNITY MEDICAL CARE

The Committee on Community Medical Care conducted its annual meeting on September 23, 1977, at Mid Pines Club in Southern Pines. There were two major items of business on the agenda:

(1) Dr. W. Burns Jones, Jr., Head of the Chronic Disease Branch of the North Carolina Department of Human Resources, led a discussion on Commercialized Multiphasic Testing. Following the discussion, a motion was made and approved requesting that the North Carolina Medical Society seek state legislation designed to regulate multiphasic health testing services.

(2) Dr. William Laupus, Dean of the School of Medicine at East Carolina University, gave the Committee a status report on the newly-developing medical school at Greenville.

Ronald H. Levine, M.D., Chairman

#### COMMITTEE ON CONSTITUTION AND BYLAWS

The Committee has considered and received approval by the Council for the following additional changes to the Bylaws:

1. Delete the Committee on Awards.

2. Increase the membership of the Editorial Board of the Journal to eight members so that there can be one member from each of the four medical schools and four members at large.

3. Provide that a member serving out an unexpired term of another member shall be eligible for re-election to that office.

These proposed changes will be incorporated into the 1978 draft of the new Constitution and Bylaws along with the changes approved at the last House of Delegates meeting. The entire document will again be submitted to a Reference Committee and will then be subject to ratification by the full House of Delegates and take effect at that time.

Louis Shaffner, M.D., Chairman

### COMMITTEE ON CREDENTIALS

The Committee on Credentials met at the conclusion of the annual meeting of the North Carolina Medical Society at Pinehurst in May 1977.

It was agreed to continue the procedure for certifying delegates which was put into practice in 1975.

A member of the Credentials Committee will be present at the desk in the Registration Booth on Thursday morning, May 4, 1978, from 8:30 A.M. to 12:30 P.M. to handle any problem which might arise regarding this procedure.

John A. Payne, III, M.D., Chairman

### ADVISORY COMMITTEE TO THE CRIPPLED CHILDREN'S PROGRAM

The Chairman of this Committee met on numerous occasions during the year with members of the Crippled Children's Program. A meeting of the full Committee was held in September 1977 and the following items accomplished:

1) The approval of guidelines and policies in regard to the support of cleft lip and cleft palate surgery and the creation of a new permanent cleft lip and cleft palate sub-committee composed of members elected from the sub-specialty societies of plastic surgery, otolaryngology, pediatrics, orthodontics and speech pathology.

2) Guidelines were approved in regard to recipients eligible for electric wheelchairs.

3) Policies were approved regarding the appointment of new Crippled Children's Program Clinic Directors.

4) Policies were approved in regard to the selection and attendance of orthotists and prosthetists at the Crippled Children's Program sponsored Orthopaedic Clinics.

5) Information was received in regard to the current status of the Scoliosis Screening Program that has, at this point, been conducted in 36 counties of the state with a great deal of success. Some 55,000 children have now been screened under this program.

Ralph W. Coonrad, M.D., Chairman

### COUNCIL ON REVIEW & DEVELOPMENT

The Council on Review & Development met during the Committee Conclave in September and handled the following items of business on the Agenda:

1. Vice Chairman Reynolds read the report from the Committee on Awards and the recommendation that the committee be discontinued. Discussion ensued and the following motion was made by Dr. Caldwell, seconded by Dr. Gilbert and passed unanimously:

THE COMMITTEE ON AWARDS BE ABOLISHED AS RECOMMENDED BY THAT COMMITTEE.

II. More discussion followed on the subject of awards and Dr. Welton offered the suggestion that the Society should evaluate North Carolina candidates for the AMA distinguished service award. Dr. Caldwell made the suggestion that the President should appoint an ad hoc committee to study this. Regarding the revolving athletic trophy, Mr. Hilliard is to contact Mecklenburg Society as to a suitable repository for same. The following motion was then made by Dr. Welton, with amendments, and seconded by Dr. Estes:

THAT THE PRESIDENT CONSIDER APPOINTING AN AD HOC COMMITTEE TO STUDY THE FEASIBILITY OF PRESENTING TWO TYPES OF DISTINGUISHED SERVICE AWARDS, FOR APPROPRIATE RECOGNITION FOR SERVICE GIVEN BY COMMISSIONERS AND COUNCILORS AND TO STUDY POSSIBLE CANDIDATES FOR THE AMA'S VARIOUS AWARDS.

III. Mr. Hilliard then brought the Council up-to-date on the status of the Administrative Code and Policy Manual.

IV. The Council next considered a request from the Committee Advisory to the Auxiliary and following discussion, a motion was made by Dr. Caldwell and seconded by Dr. Glasson:

THAT THE EXECUTIVE COUNCIL CONSIDER THE FORMULATION OF A POLICY THAT MEMBERS OF THE NORTH CAROLINA MEDICAL SOCIETY NOT BE PAID AN HONORARIUM FOR PARTICIPATION IN FUNCTIONS OF THE NORTH CAROLINA MEDICAL SOCIETY AND ITS AUXILIARY; THAT EXPENSES MAY BE PAID BY POLICY IN EXISTENCE OF THE MEDICAL SOCIETY.

V. Under Old Business, Dr. Glasson reported from the Committee on Arrangements that as far as the Hooper Memorial Lectureship, it is anticipated to engage for the Socio-economic Session, Ted Cooper, immediate past secretary of HEW and now Dean of Cornell, who will be paid an honorarium of \$500 and expenses of traveling from New York, all of which will be paid for from the Hooper Memorial Trust. Formal request will be made by the Committee on Arrangements to the Foundation in this regard.

Dr. Shaffner advised the Council on proposed Editorial Board changes, that when a vacancy comes about there should be one member from the ECU school put on the Board and that the Board should be increased from seven to eight members so there would not be a majority vote of medical school members on the Board. Bylaw changes will be required.

James E. Davis, M.D., Chairman

### COMMITTEE ON DISASTER AND EMERGENCY MEDICAL CARE

The Committee on Disaster and Emergency Medical Care met on Friday, September 23, 1977, at Southern Pines. We heard reports of the activities of the American College of Emergency Physicians, the Committee on Trauma of the American College of Surgeons, and the American Orthopedic Association. All these organizations had a considerable input into the development of a satisfactory emergency medical system in the State of North Carolina.

There was a great deal of discussion over the JCAH standards for emergency medical services, and these were discussed thoroughly and a letter was drafted through the Office of Emergency Medical Services expressing our thoughts on this document.



There seemed to be continued strides in emergency medical services through the Office of Emergency Medical Services in Raleigh. This was not to say that there were not problems which were discussed very openly and in detail at his meeting.

The duties and responsibilities of this Committee were reviewed, and it was felt that this Committee was carrying out its responsibilities as developed by the Medical Society.

One of the main functions that we saw ourselves as doing was as a forum for free communication and exchange of ideas from various groups interested in emergency medicine.

George Johnson, Jr., M.D., Chairman

### COMMITTEE ON DRUG ABUSE

The Committee on Drug Abuse had 100 percent attendance at its Southern Pines meeting on September 23, 1977. The Committee recommended to the Executive Council that the injectable form of Pentazocine (Talwin) be placed under controlled substances in Schedule IV.

Approval was expressed in the form of a motion endorsing the formation by the Medical Society of a new committee on Physician Health and Effectiveness.

Following general discussion a final motion was passed stating: "The Committee on Drug Abuse recommends that the Executive Council of the North Carolina Medical Society inform all physicians in the State of the problem of patients receiving mind altering drugs from Veterans Administration facilities without frequent face to face contact between physician and the patient."

On December 4, 1977 the Committee held a special meeting in Raleigh in order to focus solely on the issue of drug abuse in North Carolina, the role of the Medical Society and in particular the possible role of this Committee. The consensus during a two hour meeting was that the most significant and useful thing that the Committee could immediately do would be to warn fellow physicians of the dangers to patients of developing iatrogenic dependence on prescribed drugs such as minor tranquilizers and sleeping medications. The importance for all physicians of writing prescriptions for small numbers of such medicines and of seeing patients for follow-up rather than issuing replacement prescriptions was emphasized.

To pursue this topic further the Committee plans to have a joint meeting with representatives of North Carolina pharmacists.

John A. Ewing, M.D., Chairman

### COMMITTEE ON EXHIBITS

Once again the Committee on Exhibits was proud of the fine collection of educational Scientific Exhibits which was presented at the 1977 Annual Meeting of the North Carolina Medical Society and pledges to present an array of exhibits, equal in excellence, at the 1978 Annual Meeting.

The Committee is pleased that its efforts to strengthen fellowship with the technical exhibitors has been successful. We continue to find the available exhibit space completely subscribed for each Annual Meeting in spite of a contrary national trend.

By January 1, 1978, the Committee had solicited and accepted its full quota of both Scientific and Technical Exhibits and now looks forward to an educational and successful 1978 Annual Meeting.

Josephine E. Newell, M.D., Chairman

### COMMITTEE ON EYE CARE AND EYE BANK

The Committee on Eye Care and Eye Bank met at Mid Pines, September 1977. The Committee resolved that optical dispensing facilities owned wholly or in part by physician or group of physicians shall not be operated in a manner designed to exploit the patient or designed to conceal its ownership or mislead the patient in any manner.

A registry of adverse drug reactions and improper practice of medicine has been established and notification to all ophthalmologists in the state has been made and several reports of adverse reactions have been received.

The Committee resolved to recommend that the Executive Council of the State Medical Society do all within its power to advise the North Carolina Medical Society delegates to the AMA to propose to the AMA that the specialty of ophthalmology be designated as a primary care specialty and to be so represented in the AMA structure.

Albin W. Johnson, M.D., Chairman

### COMMITTEE ON FINANCE

The Committee on Finance met on September 11, 1977, and prepared a budget for 1978. There were two large changes in the Budget, the first being the change in dues structure increasing the income, and the second being a considerable increase in expenditures in the Communications Budget. It had been anticipated that the 5% of the Revenues would be allocated to the Operating Reserve Fund as had been done in earlier years, but this proved impossible to do, and with the permission of the Executive Council, this was eliminated.

During the year, the sale of 3.64 acres of the Raleigh corner of the NCMS property on Highway 70 was completed to B & B Properties for a sum of \$61,000. The completed sale was added to the Operating Reserve Fund by the auditor and this sale plus interest from the fund itself brought the fund up to \$403,000 as of December 31, 1977.

In addition, an option on the remaining property was sold to Mr. E. E. Carter for \$2,000. This option was for purchase of the property for \$240,000. On February 28, 1978 this sale was completed and placed in the Operating Reserve Fund. Deducting the realtor's fee for sale of the property to Mr. E. E. Carter and adding \$37,000 due on a loan from the reserve fund to purchase an IBM System/32 computer for the headquarters office brings the present value of the Operating Reserve Fund to about \$667,000.

It is anticipated that with the present dues structure, the Operating Reserve Fund will, within the next two to three years, reach the one year's Operating Budget as ordered by the House of Delegates and that no additional dues increase will be required until, by normal growth, the Operating Budget will utilize the additional dues from the new members as well as the present dues of \$140 per member.

T. Tilghman Herring, M.D., Chairman

### GOVERNOR'S COORDINATING COUNCIL ON AGING

I have represented the Medical Society on the Governor's Coordinating Council this year. I have been able to attend most of the meetings. These have been interesting and I believe have made a useful contribution to furthering the best interests of our older citizens.

I have had an opportunity to speak out on any issue where I felt a medical opinion would be germane. The meetings, chaired by Dr. Ellen Winston, are run in a very orderly, democratic fashion and there is ample opportunity for in-

take. Most of the material covered by the Council, however, is sociological in nature and aimed at influencing legislation or executive practice in areas that are not specific to medical practice.

I have very serious question as to whether it is worthwhile to have physician sitting in on each meeting for the full length of the meeting. I think it might be a better arrangement to have a physician designated to represent the North Carolina Medical Society who could be present for any meeting that has a medically specific subject on its agenda.

Robert N. Harper, M.D., Representative

### COMMITTEE ON HEALTH PLANNING & DEVELOPMENT

(not received as 3-8-78)

### COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS AND LIAISON TO THE NORTH CAROLINA HOSPITAL ASSOCIATION

At the committee meeting at Mid Pines on September 23, 1977, this committee moved that it would move toward educating its members and meeting with the members of the Hospital Association and board of trustees of various hospitals with eventuality of extending an education program statewide and improving communications between doctors hospital administrators, and board of trustee members. On October 28, 1977, the chairman of the committee met with Dr. Estes and members of the North Carolina Hospital Association and it was decided that a meeting would be held with the executive councils of both the North Carolina Hospital Association and the North Carolina Medical Society on February 16 in Charlotte, North Carolina. The agenda for this meeting which had not yet been held at the time of this report was to consider 1) contractual relationships between hospitals and physicians, 2) discoverability statutes, 3) interprofessional aspects of various controls by the federal government, and 4) public education programs. It is the hope of this committee that this will precede in a state education program to improve communications between hospital staffs, administrators, and boards of trustees over the entire state.

W. W. Fore, M.D., Chairman

### COMMITTEE TO WORK WITH THE NORTH CAROLINA INDUSTRIAL COMMISSION

This year's work of the Committee was characterized by good relationship with the Industrial Commission and good work by members of the Committee. Committee members present at the annual committee meeting were LeRoy Allen, Tom Castelloe, Carl Hiller, Jack Hobson, Julius Howell, Tom Kerns, Bob Means, Bob Miller, Charles Nance, Tom Koontz, Richard Furman, Mike Segal and Paul Long.

Dr. A. E. Harer, the new Medical Director of the North Carolina Commission attended the meeting as did William Stevenson, the Commissioner along with Deputy Commissioner Forrest Shuford and Chief Medical Fee Examiner Mrs. B. J. Moore. Ms. Elenor Ross, Chief of Rehabilitation Section also attended. Commissioner Stevenson announced that the new fee schedule should be out by the Spring of 1978 and that the new schedule would use both 5 digit codes as well as the old RVS code. He also announced that new claim

forms are being distributed which will replace both Form 2 and Form 25.

E. B. Spangler M.D., Chairman

### INSURANCE INDUSTRY COMMITTEE

The Insurance Industry Committee met formally on three occasions during the year and completed claims review of some sixty cases involving questions of insurance carrier liability. Most cases are reviewed at the request of insurance companies, but some were reviewed because of patient and/or physician request.

Revision of the handbook outlining the composition, duties and purpose of the committee was completed. Copies were distributed to all members of the committee and representatives of various insurance claims offices in the state and other regions. A new form for submission of claim was also developed, making review much more efficient.

This has been an exceptional committee in its liaison between the physicians of North Carolina and representatives of the insurance industry. The members have given careful consideration in the mediation of claims problems. This Medical Society has the respect of the industry because of these efforts. We can be very grateful for the input of these physician members and also for the untiring efforts of Mr. Gene Sauls.

Charles H. Duckett, M.D., Chairman

### COMMITTEE ON LEGISLATION

The 1977 General Assembly focused its attention on a variety of health care issues, some of which are highly controversial and continue to be studied by legislative study commissions. Most of the legislative efforts of the Medical Society were rewarded thanks to the continued assistance from Mr. John Anderson and Mr. Stuart Shadbolt and through the efforts of many of our dedicated physicians who realize the importance of becoming politically involved in medical affairs.

As members of the North Carolina Medical Society, you are the key to all health care legislation that is passed. Individual physicians must maintain good relations with their legislators to produce effective changes in the health care system. I urge you to stay politically alert and to voice your opinion to those who represent you.

The bills that were passed during the 1977 General Assembly pertaining to health care are summarized on the following pages. Not all the bills are mentioned, but these are the highlights of the efforts expended by the Medical Society to represent the membership in all health-related areas.

**Chiropractors (SB 341)** — The chiropractor licensing law has been amended to: 1) give chiropractors access to diagnostic x-ray and laboratory records relating to their patients; 2) prohibits any agency administering relief, social security, health insurance, or health service from denying the recipients of their aid the freedom to choose a chiropractor as a health care provider; 3) chiropractors be able to testify in a court of law as to etiology, diagnosis, prognosis and disability; 4) raise application fee and renewal fee from \$25 to maximum of \$100.

**Health Maintenance Organizations (HB 276)** — This act authorizes nonprofit corporations to operate voluntary nonprofit health care plans, HMO's. The corporations are to be licensed and regulated by the Commissioner of Insurance.

**Immunizations: (HB 315)** — This act adds rubella to other immunizations required of children residing in this state.



**Medical Cost Containment (HB 630)** — A Legislative Commission on Medical Cost Containment was created and consists of six members from the Senate and six members from the House. The commission will file a final report by April 1, 1979.

**Mental Health** — All bills proposed by the Mental Health Study Commission were enacted.

**Minors (SB 336)** — This act provides that minors 17 years of age may donate blood without parental consent. HB 370 authorizes various health services be offered to minors without consent of parents; i.e., contraceptives and pregnancy tests. HB 1166 provides that emergency medical services be offered to minors without parental consent.

**Nursing Home Patients' Bill of Rights (H 1015)** — This act guarantees patients certain rights as occupants of the nursing home and applies to all nursing homes and homes for the aged in North Carolina.

**Optometrists (SB 424)** — This act redefines optometry as the examination of the human eye by any method other than surgery to diagnose, to treat, or to refer for consultation any abnormal condition of the human eye.

**Physician's Assistants/Nurse Practitioner (HB 1216)** — This bill permits registered and licensed practical nurses to carry out the orders of physician assistant and nurse practitioners under certain conditions.

**Right to Die (SB 504)** — This bill permits extraordinary means of life support to be withheld or discontinued under supervision of attending physician if patient has executed a "living will" (document requesting that artificial life-support systems not be used when patient's condition is incurable and terminal). The act also permits the physician along with a committee of three other physicians to pronounce a person dead when his condition is terminal and incurable.

**Wound Reporting (SB 427)** — This act requires all physicians and administrators of medical facilities to file wound reports with the police in the city or town where the injury was treated.

Archie T. Johnson, Jr., M.D., Chairman

that the activities of this Committee can over a period of time effect some changes in the educational system of the state.

Luther M. Talbert, M.D., Chairman

## COMMITTEE ON MATERNAL HEALTH

The Committee on Maternal Health has collected files on 11 maternal deaths from the Vital Records Branch of the Division of Health Services for 1977. This is the smallest number of maternal deaths ever recorded for one year since the Maternal Mortality study began in 1946. It is of historic interest that the first maternal mortality report recorded 392 deaths. This report covered the period from August 1, 1946 to May 1, 1948. Death was attributed to hemorrhage in 115 of these cases while 111 were classified as toxemia; 73 infection; 15, anesthetic; 17, heart disease; and 55 were due to causes other than maternal. Of this number 281 were thought to have been preventable, 13 non-preventable. This vast reduction in maternal mortality is indicative of the monumental improvement in the quality of maternity care in North Carolina over the past 30 years.

The 11 maternal deaths analyzed in 1977 by cause were:

Embolism	1
Cardiac	2
Hemorrhage	2
Toxemia	4
Non-obstetrical	2

There were six non-white and five white deaths which occurred, one each in the following counties:

Bladen, Buncombe, Caldwell, Guilford, Hertford, Mecklenburg, New Hanover, Robeson, Wake, Wayne, Wilson.

The Annual Meeting of the full Committee on Maternal Health convened on Wednesday, September 21, 1977 at Southern Pines, N.C. A review of 206 maternal deaths which occurred from 1971 through 1975 was presented. This information is published in detail in the North Carolina Medical Journal, Volume 39, February 1977. The topic of premature rupture of the amniotic membrane from the point of view of the pediatric perinatologist and the obstetric perinatologist was discussed by Dr. Robert Dillar and Dr. Edward Bishop, pediatrician and obstetrician respectively.

There have been two compelling issues during the year concerning maternity care. The lay midwife problem remains a continuous one and the following resolution was passed by the Committee and approved by the Executive Council as follows: "Therefore, be it resolved that the Committee on Maternal Health recommends to the Executive Council of the North Carolina Medical Society that the Medical Society go on record as recommending the repeal of the regulatory statute which allows the Department of Human Resources, Division of Health Services, to license untrained lay people for the purpose of obstetrical delivery." The Chairman has continued to pursue this question as a member of the Ad Hoc Committee of the Division of Health Services of the Department of Human Resources.

The Committee discussed the possible effects which are expected to result from the Department of Health, Education and Welfare decision to no longer pay for Medicaid eligible abortions under Title XIX. After a great deal of discussion, the following recommendation was made to the Executive Council: "Be it therefore resolved that the Committee on Maternal Health recommend to the Executive Council that the North Carolina Medical Society go on record as opposing the Department of Health, Education and Welfare elimination of payments for abortions of the poor and indigent; that the Medical Society actively seek to influ-

## COMMITTEE ON MARRIAGE COUNSELING AND FAMILY LIFE EDUCATION

The year 1977 has been an active one for the Committee. Two meetings of the Committee were held on the following dates and places:

Chapel Hill, N.C. March 22, 1977

Southern Pines, N.C. September 22, 1977

Activities during the year carried out by this Committee included solicitation of letters of support for Family Life Education in the Public School Systems of North Carolina from the North Carolina OB/GYN Society, the North Carolina Psychiatric Society and the North Carolina Academy of Family Physicians. Letters were sent to Mr. Craig Phillips who is Superintendent of Public Instruction.

In addition plans were made to present a half day program at the State Medical Society Meeting, 1978 pertaining to Family Life Education. This will consist of two panel discussions, one dealing with the care and treatment of the rape victim and the family and one on sex education and preventive medical measures.

In addition two movies will be shown during the audiovisual program entitled "Sex and the Professional" and "Sex and Communications."

In summary this Committee has been considerably more active during 1977 than in previous years and it is our hope

ence the Legislature of North Carolina to make funds available for abortions to the poor and indigent." The Chairman later appeared before the Commission on Social Services of the Department of Human Resources in behalf of this recommendation and approval has been made by this Commission for the payment of indigent abortions with State funds.

A report on the Southeastern Pilot Program on Perinatal Care indicates that fetal deaths appear to have decreased in southeastern North Carolina in the counties of Bladen, Columbus, Hoke, Robeson and Scotland because of the Pilot Program.

Reimbursement has been received in the amount of Three Hundred Dollars to help cover expenditures for secretarial help, mailing, supplies and telephone expenses incurred in the course of conducting the work of the Committee for the past year. A detailed report of the disbursement of these funds has been previously submitted to the Controller of the Medical Society.

On behalf of the Committee on Maternal Health, the Chairman expresses appreciation to the Executive Council and the Staff of the North Carolina Medical Society for their support and cooperation in the activity of the Committee on Maternal Health.

W. Joseph May, M.D., Chairman

#### COMMITTEE ON MEDICAL ASPECTS OF SPORTS

A meeting of the Committee on the Medical Aspects of Sports was held on July 1, 1977, in conjunction with the 1977 Sports Medicine Symposium. The major items considered at this meeting were (1) planning for the 1977 Sports Medicine Symposium, (2) a report from the Division of Sports Medicine of the Department of Public Instruction by Dr. Al Proctor, and (3) a report on progress in the establishment of a Governor's Council on Physical Fitness and Health in North Carolina. In the absence of the Subcommittee Chairman, there was no report from the Subcommittee on the Physician of the Year Award.

In relation to the 1977 Sports Medicine Symposium, it was decided that registration for the Sports Medicine Symposium would be limited to physicians but that paraprofessionals might attend as paying guests of one of the physician registrants.

The registration for the 1977 Sports Medicine Symposium was approximately 100 applicants, making this the best attended symposium since they were begun seven years ago. The guest speaker was Dr. Rollie Tillman, Director of the Young Executive Program at the University of North Carolina. The major emphasis of the symposium was on the responsibility of County Medical Society Chairmen for sports medicine, and organizational plans were presented for both large, small, and medium sized communities. Other topics considered were sidelines physicians' duties, legal liability in high school athletics, and the initial management of acute football injuries. The symposium also heard a presentation on eligibility requirements and rules in North Carolina Public Schools. Questionnaires from those who attended the symposium indicated that the program was well received, and it is the hope and feeling of the committee that these annual symposia will serve an increasingly important function in the education of North Carolina physicians in the medical aspects of sports.

An editorial was written by the Committee Chairman for the North Carolina Medical Journal outlining the development of sports medicine programs in North Carolina and calling for increased community participation in sports medicine programs by the physicians of the state.

Frank C. Wilson, M.D., Chairman

#### COMMITTEE ON MEDICAL COST CONTAINMENT

The Committee on Medical Cost Containment met three times during 1977: March 13; September 21; and November 20.

The following were activities of note:

1. Sent a press release to the public relations committee concerning the activities of this committee.

2. Requested that the Deans of the Medical Schools include the costs of medicine in their formal curriculum.

3. Developed and almost completed a pamphlet on Cost Containment which can be placed in physicians' offices for public to read.

4. Recommended to the Legislative Study Commission the following:

A. That they investigate the possibility of reimbursement for home custodial care for eligible and suitably approved individuals.

B. That they examine some of the programs in nearby states, particularly Virginia.

C. That they establish a reimbursement structure whereby Acute Care Hospitals could be paid for patients days of care at the Intermediate Care Facility rates.

5. Initiated a project which would make it possible for reimbursement for expenses incurred for out-of-hospital surgery.

Jesse H. Meredith, M.D., Chairman

#### COMMITTEE ON MEDICAL EDUCATION

The Committee's activities during 1977 and early 1978 were related mainly toward the completion of the first continuing medical education reporting cycle for the majority of the members of the Society. The Committee has been actively involved in assisting the membership in answering questions concerning the continuing education requirements and resolving problems that have arisen.

The Executive Council of the Society at its February meeting voted, on the recommendation of the Committee, to extend the reporting period for continuing medical education until December 31, 1978. This extension is to allow those physicians who have not yet submitted their medical education records an opportunity to complete the requirement. The Council also stated that those hours earned during 1978 cannot also be applied toward the current medical education cycle which began on January 1, 1978.

One area of concern was what would justify an exemption from meeting the medical education requirements of the Society. After a long discussion the Committee decided that as long as a physician was making clinical judgments that affect his patients then he should not be granted an exemption.

An additional action of the Committee was to adopt the American Medical Association Physician Recognition Award requirements instead of the requirements previously adopted.

The Committee on Medical Education lost one of its most valuable members on January 22, 1978. Oscar L. Sapp, III, M.D., Assistant Dean for Continuing Medical Education at the School of Medicine at UNC, died after attending a meeting of the Committee. Dr. Sapp had served on the Committee since 1973. He will be missed by all who knew him.

John D. Bridgers, M.D., Chairman

#### MEDIATION COMMITTEE

The Mediation Committee, consisting of the five immediate past presidents of the North Carolina Medical Society, has continued to function with a slowly increasing



number of matters referred to it by the Headquarters Office of the Medical Society.

The committee is designated to receive and consider almost any complaint involving the practice of physician members of the North Carolina Medical Society and to try to resolve the problem involved fairly and to the satisfaction of all parties concerned. The committee does not consider, as a matter of policy, those cases in which legal action has been instituted.

Most of the matters considered continue to involve physician-patient contact in Emergency Rooms, contact involving transient patients, and other situations where a continuing and good physician-patient relationship has not been established.

Occasional cases involving problem relationships between physicians, problem relationships between physicians and public agencies are received, considered and dealt with.

In general, the committee continues to serve a useful function in maintaining good relations between North Carolina Medical Society members and the public, and in most instances can open up lines of communication and promote understanding with regard to the matters referred to the committee.

John Glasson, M.D., Chairman

#### MEDICAL-LEGAL COMMITTEE

I. Two meetings were held during the year. These were at Southern Pines on September 21, 1977 and Raleigh on January 22, 1978.

II. The committee has indicated interest in the amount of coverage of suits against physicians on punitive damages. It was recommended that the Medical Liability Mutual Insurance Company investigate this problem.

III. The Medical-Legal Committee of the North Carolina Bar Association has recommended a joint meeting of the two committees and this will be arranged.

IV. In an effort to find solutions to the malpractice problem the committee has recommended: 1. the Medical-Legal Committee of the North Carolina Medical Society and the North Carolina Bar Association review the rationale of all legislation sought, passed or not passed, during the 1976 session of the legislature; 2. that a meeting be arranged between the Medical-Legal Committee and concerned legal authorities to attempt to arrive at a consensus of an ideal legislative solution to the malpractice problem.

V. A committee has been appointed to evaluate malpractice matters and to consider the probability of public meetings. Committee members are: Ira M. Hardy, M.D., Chairman; Henry D. Severn, M.D.; Angus M. McBryde, M.D.; Edward B. McKenzie, M.D.; and Arned Lee Hinshaw, M.D.

VI. Approximately twenty-five joint county meetings of the Bar and the Medical Society were held during the year.

VII. It was noted that more inquiries were received this year in regard to malpractice matters than any previous year.

Julius A. Howell, M.D., Chairman

#### COMMITTEE ADVISORY TO MEDICAL STUDENTS

The Committee Advisory to Medical Students met and considered the following goals for its work:

1) To increase recruitment and interest of medical students in the State Medical Society. This has been followed through with letters and calls to the four medical schools and

particular involvement of the East Carolina Medical School with a visit to them by student members from the Chapel Hill School.

2) Consideration of disbursement of the budget for the Committee which, in the past, has gone to the funding of a student delegate from each of the medical schools to the AMA annual meeting in St. Louis and to the American Medical Student Association. This was considered, approved, and will be carried through by the State Medical Society.

3) Consideration of ways of involving the medical students in the annual meeting at Pinehurst. This will be worked on in the spring and hopefully delegates from each of the schools will be evident at that meeting.

James A. Bryan, II, M.D., Chairman

#### COMMITTEE ON MENTAL HEALTH

The year 1977 has been a very important one for mental health activities both on a state and national level. One of the most important events on the state level was the resignation of Dr. N. P. Zarzar as Director of the Division of Mental Health Services for the state of North Carolina. Other extremely capable and able staff members left the division. It was the feeling of some of us that any director of the Division of Mental Health Services should be both an excellent psychiatrist with unquestioned training and experience as well as an excellent administrator. The state apparently wasn't able to find someone with this type of background to replace Dr. Zarzar but they were fortunate in persuading Mr. Ben Aiken, a man who has an excellent reputation as a top-notch administrator, to accept the position of Director of the Division of Mental Health Services.

The September meeting was chaired by Wilmer C. Betts M.D. in my absence and under his very able leadership some very constructive recommendations were made to the Executive Council. Dr. Robert Gibson reported at the December meeting of the activities of the ad hoc Committee on the troubled medical provider. It was recommended that this ad hoc Committee be changed in title to "Committee on Physician Health and Effectiveness" and this has indeed been accomplished.

The North Carolina Medical Society once again co-sponsored the Alcoholism Awareness Week which was held in Greensboro in the third week of January of 1978. It was held in conjunction with a meeting of the International Doctors in Alcoholics Anonymous and was organized by the N.C. Alcoholism Research Authority.

For the leadership of Dr. Betts and for the every present concern and interest of the committee members in the mental health problems of North Carolina, we are extremely grateful.

Philip G. Nelson, M.D., Chairman

#### ADVISORS TO N. C. ASSOCIATION OF MEDICAL ASSISTANTS

The American Association of Medical Assistants, North Carolina State Society, has had another very successful year, and is continuing its efforts to provide exceptional educational programs for Medical Assistants throughout the State.

Two very successful and well attended educational seminars have already been held this year, the first in Asheville in August, and the second in Jacksonville in November. A third is scheduled to be held in Charlotte in February. These

programs are being planned in such a manner as to merit the awarding of Continuing Education Units based on the national standard, and the attendance at these meetings is evidence of the interest Medical Assistants have in increasing their knowledge and proficiency.

The State Society continues to show remarkable growth with the following five new county chapters being organized this past year: Nash, Alexander, Alamance, Duplin, and Rutherford. The addition of these new component chapters brings the total State membership to approximately 900, placing the North Carolina Society in the top third among the State Societies in the country. For the third year in a row, the North Carolina State Society won two membership awards at the national convention held in San Francisco in October.

There continues to be a great interest in the national Certification Examination, with each year showing an increase in the numbers of Assistants sitting for the examination. This examination is now being administered by the National Board of Medical Examiners, and all physicians should encourage their Assistants to sit for certification.

The Annual Convention of the State Society will be held in Greensboro at the Four Seasons Holiday Inn, April 28-30, 1978. Information regarding this program will be mailed to all physicians' offices.

It is a real pleasure to be associated with this fine organization, and the advisors to the North Carolina State Society feel that the physicians in our State should be very proud of the efforts their assistants are making toward continuing education. We believe it behooves us all to encourage and support our assistants in these efforts.

John A. Brabson, M.D.,  
Royal G. Jennings, M.D.,  
Wayne B. Venters, M.D.,  
Advisors

#### COMMITTEE ON OCCUPATIONAL AND ENVIRONMENTAL HEALTH

The Committee on Occupational and Environmental Health met once during 1977 at the Annual Committee Conclave in September. The committee continues to function as a forum for discussion of medical problems related to occupational medicine.

One of the major topics of discussion was Byssinosis but this time in connection with a number of "Brown Lung Clinics" being conducted statewide by nonprofessionals. Local medical authorities are often unaware that these screening clinics are being conducted in their areas. After a lengthy discussion the committee recommended that a subcommittee of its members approach the Secretary of the Department of Human Resources to confer on this and other problems.

Other items considered by the committee included the "Effective Hearing Conservation Program" sponsored by the N.C. Department of Labor, the Center for Occupational Health and Safety at UNC, and the confidentiality of medical records relating to occupational and environmental health.

Charles F. Martin, M.D., Chairman

#### COMMITTEE ON PERSONNEL AND HEADQUARTERS OPERATION

The Committee met on September 7, 1977. There is still 2,000 sq. ft. of vacant office space in the

Society's headquarters building. The committee agreed that in order to attract desirable tenants, the Society should be more liberal in meeting the requirements of prospective tenants.

Staff salaries were discussed and recommendations sent to the Finance Committee.

A proposal for a Society-leased or Society-owned automobile was thoroughly discussed by the committee. It was the consensus that the cost to the Society would be the initial outlay for the purchase. Maintenance and replacement costs would be taken care of by the decrease in our present cost per mile outlay to executive officers using their own cars. The committee recommended to the Committee on Finance that a Society-owned automobile be purchased for the use of the Executive Director effective January 1, 1978, and that the Executive Director pay \$25 per month for personal in-town use of the automobile, plus all expenses for any personal out of town driving. The Committee on Finance later voted down this recommendation.

A group disability income plan for 7 of the executive staff was discussed. The committee approved the concept but wished to have other insurance company proposals for comparisons.

A proposed revision of the Staff Organization chart involving several new staff titles was discussed and approved.

A. Hewitt Rose, Jr., M.D., Chairman

#### COMMITTEE LIAISON TO NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

The Committee convened on September 23, 1977 to transact annual business including the authorizing of three physicians to be dispensing physicians. A discussion of the generic substitution provision of the state appropriations act determined that the anti-substitution law had not been voided but only amended in regard to prescriptions written for MEDICAID patients.

Following a discussion of the recently passed optometry bill the committee passed a motion to the effect that for the benefit of both the patient and the pharmacist, the pharmacist filling a prescription written by an optometrist should attempt to ascertain which physician was collaborated with by the optometrist.

Reinforcing their consensus that patients are best informed about the effects of medication by prescribers rather than by package inserts, the committee passed a motion to the effect that information regarding medications should more appropriately come from the prescriber rather than from package inserts.

The committee also endorsed the position of the North Carolina Medical Society regarding the policy on Laetrile.

Charles W. Byrd, M.D., Chairman

#### COMMITTEE ON PHYSICIANS' HEALTH AND EFFECTIVENESS

The Committee met for the first time as a continuing committee on January 21, 1978 in Greensboro. The work of the Ad Hoc Committee was reviewed and Dr. Clark was authorized to work up a plan for North Carolina based on a modification of the Ohio State Medical Association plan which has been in effect since 1975. The Physician Health Effectiveness Program (PHEP) is guided by six general principles:

1. Be motivated by humanitarian concerns for the public and the impaired physicians.



2. Recognize that alcoholism, drug abuse, and mental illness among physicians are too often ignored or untreated.

3. Recognize that alcoholism, drug abuse, and mental illness are treatable conditions — and that treatment and rehabilitation personnel skilled in these areas have a good success record.

4. Encourage all impaired physicians to seek help and cooperate in treatment at the earliest possible time in order for them to retain or regain full effectiveness to practice.

5. Employ *constructive coercion* if a physician refuses all offers for assistance at a time when his impairment poses a threat to reasonable delivery of medical care.

6. Employ *involuntary coercion* where all (other) efforts have failed and the physician's impairment threatens the public or physician's health.

Effective as of January 21, 1978, the North Carolina Medical Society Physician Health Effectiveness Program became official for the express purpose of aiding physicians who develop problems such as alcoholism or drug addiction or mental illness. The program is organized by means of three options for extending assistance to impaired physicians. Personnel involved include the chairman of the program, a North Carolina Medical Society staff member and an intervention team consisting of a pair of physicians (whenever possible, one such physician should have recovered from the same problem as the physician to be called upon). In addition, family members of the impaired physician, hospital administration and medical executives could enter into a particular case.

All assistance is triggered by calling the established North Carolina Medical Society telephone number (919/833-3836) and asking for the Physician Health Effectiveness Program staff person.

Regardless of the option, the work of the volunteer interveners is most vital to the operation of the program. Following the initial call to the North Carolina Medical Society staff person, the Intervention Team (I.T.) must first determine whether or not the physician has a bona fide problem (assuming that the physician has not called for help himself). They then serve as confronter and urge the physician to acknowledge his problem and begin treatment. The Intervention Team will do everything possible to convince the physician of the magnitude of his problem. If this fails, the Intervention Team is empowered to notify the Committee Chairman and turn the case over to the Board of Medical Examiners of the State of North Carolina (this board has the power to suspend license to practice).

### Option I

When the impaired physician himself seeks guidance and referral through the PHEP, the following sequence of events results under the provisions of Option I of the program:

1. The impaired physician calls the established telephone number of the North Carolina Medical Society; gives his name, address, and telephone number; and indicates his desire for medical help.

2. The appropriate staff member contacts the Committee Chairman who, in turn, contacts an appropriate Intervention Team for the physician involved. It may be appropriate to send in an Intervention Team from outside the doctor's catchment area.

3. The Intervention Team contacts the impaired physician, inquires about the nature of his illness or problem, and discusses appropriate evaluation and treatment arrangements.

4. The Intervention Team contacts the treatment program, psychiatrist or other physician considered most ap-

propriate to care for the impaired physician and informs him of the general nature of the problem.

5. The impaired physician enters treatment with the treatment program or attending physician, ending the PHEP's involvement.

### Option II

The option also exists for a concerned peer (another physician practicing in the same community) to contact the PHEP regarding the possibility that a fellow physician might be ill and in need of assistance. In this case, the following sequence of events results through Option II:

1. The concerned peer calls the established telephone number of the NCMS, giving his own name, address, and telephone number; the name of the colleague whose health is considered questionable; and the specific reasons for concern. The initiating physician will be guaranteed subsequent anonymity, but should be required to identify himself to assure that he is indeed a physician in order to minimize the risk of frivolous or vindictive calls. The Medical Society also expects to continue to field calls from concerned patients or family members and these will be considered on their own merit.

2. The appropriate staff person contacts the Committee Chairman and the Intervention Team.

3. The Intervention Team checks with the appropriate individual or committee of the local county medical society to determine whether, in the society's judgment, there is sufficient reason to believe the physician in question to be ill. This does not require any initiative on the part of the county medical society, but simply confirmation from it that other physicians share the concern that this colleague might be ill.

4. The Intervention Team reports to the Committee Chairman that sufficient cause exists to justify contacting the physician thought to be ill.

5. Such contact is first made in writing by the Chairman, explaining the nature of PHEP, the general circumstances leading to the letter (preserving anonymity for all individuals involved), and stressing the desirability of the physician seeking appropriate evaluation and treatment. This letter indicates that the Intervention Team will contact the physician personally to make appropriate arrangements.

6. The Intervention Team contacts the sick physician and offers to help if any problem exists.

7. If the physician in question acknowledges his illness and need for assistance, the Intervention Team makes arrangements for an appropriate treatment program, including a follow-up therapist and a follow-up monitor. The Monitor *must* be a separate person from the Therapist and might be the person's chief of staff or some other agreed upon member of the Medical Society, etc.

8. The impaired physician enters treatment as agreed by all parties concerned.

9. The only further contact between the Therapist/Monitor and the Intervention Team is the former's confirmation that the sick physician is indeed undergoing appropriate treatment.

10. The Intervention Team reports to the Chairman that no further action on the PHEP's part is indicated. Thus, no contact is made with the Board of Medical Examiners of the State of North Carolina.

### Option III

In some cases, the physician whose health is in question may deny any illness and refuse suggestions of evaluation or offers of treatment. Under this circumstance, Option III

must be employed. This option follows Option II through step six, where it differs as follows:

7. If the physician in question denies any illness or refuses assistance, the Intervention Team reports this to the Chairman. Similarly, if the physician in question agrees to a treatment program, but does not do so, a report of this action is made.

8. After a suitable interval, the Chairman again writes to the physician in question, urging him to seek assistance and pointing out the program's responsibility to turn the situation over to the Board of Medical Examiners if no corrective action is taken voluntarily.

9. The Intervention Team follows with telephone contact, stressing the same points as the Chairman.

10. If the physician in question still denies illness or declines assistance, the Intervention Team again reports to the Chairman. The Chairman communicates the facts of the case to the Board of Medical Examiners, preserving the anonymity of the original concerned peer and of specific individuals contacted by the Intervention Team in the local county medical society. The PHEP's involvement ends at this point until such time as the Board of Medical Examiners may decide to turn the case back to PHEP for follow-up.

The role of the Intervention Team is to serve as a broker between the sick physician, the people complaining, the intended treatment plan and that person or persons designated to monitor the success or failure of the patient progress, e.g. a given chief of service calls the Medical Society telephone number and states the problem concerning one of his physicians. Through one of the options outlined above, treatment is obtained and becomes an ongoing process. Part of the treatment contract calls for the original chief of service to monitor the successful outcome of the patient's treatment. If there is trouble, the Monitor (not the patient's therapist) is expected to recontact the original Intervention Team to set up a new treatment program. Confidentiality of all parties concerned is respected up to, but not including, Option III. In Option III, the Committee stops buffering any complaints and allows them to go through to the Board of Medical Examiners. However, the anonymity of the original complainants dealing with PHEP will be respected.

Under all options of the Physician Health Effectiveness Program, the goal is to assist the impaired physician so that he can preserve his own health — thus, allowing him to proceed in his primary mission of treating patients in the most effective manner. This will benefit his patients, family and friends alike. Plans are also being made by the Committee to set up educational programs for medical students, interns and house officers and lectures have already been set up to involve the Auxiliary who should prove to be an ally to the treatment process. Any questions regarding the Physician Health Effectiveness Program should be directed to the North Carolina Medical Society, 222 N. Person Street, P.O. Box 27167, Raleigh, North Carolina 27611, telephone 919/833-3836. A brochure is being prepared and, upon publication, will be sent to all Medical Society members.

Theodore R. Clark, Jr., M.D. Chairman

#### MEDICAL SOCIETY CONSULTANT ON PODIATRY

There were several inquiries made to me as consultant on podiatry this past year regarding the applications of several podiatrists to hospital staffs throughout the state. The present guidelines were presented to the inquiring physicians.

It was recommended that each applicant be given hospital and/or surgical privileges according to his or her individual qualifications and training.

Follow-up information concerning these inquiries was not then subsequently made to me.

Donald B. Reibel, M.D., Consultant

#### COMMITTEE ON PROFESSIONAL INSURANCE

The Professional Insurance Committee of the North Carolina Medical Society meets quarterly to consider inquiries concerning all types of professional insurance for physicians. The Committee reviews all types of insurance programs and makes recommendations to the Executive Council for final action. The Committee continues to enjoy an excellent working relationship with the professional liability insurance carriers in North Carolina.

John C. Burwell, Jr., M.D., Chairman

#### COMMITTEE ON REHABILITATION MEDICINE

The major item of business of the Committee during the past year has been its concern with the problem of Amputation Clinics and Prosthetics in the State. One meeting was held in Raleigh of the Amputee Clinic Chiefs under the auspices of the Committee on Rehabilitation Medicine.

A sub-committee under the Chairmanship of Dr. Christopher Siewers of Fayetteville has been named to study the problem of Amputation Clinics and Prosthetics in more detail. This study is now in progress.

Another matter which has been of concern to the Committee and which further study is planned is the problem of standardization of disability evaluations and ratings.

E. H. Martinat, M.D., Chairman

#### RETIREMENT SAVINGS PLAN COMMITTEE

The Society's plan for retirement savings funds has enjoyed much less success than might have been anticipated. The reasons for this, of course, are problematical; but two major factors have occurred to us.

1. We do not know the exact percentage of the Society's membership that is incorporated but it is steadily increasing.

2. United States industry is facing a novel situation and traditional equity values are upset.

The long term thinking of this Committee was to have the members' funds either in equities of sound industries (shares in America) or in an annuity for those wishing absolute predictable withdrawals. The small number of participants in the last two or three years have influenced the committee to add a third option, that is the investment of funds in money instruments. While this has only been available for the last nine months due to the long waits in getting revenue service approval, so far it has not stimulated a large increase in interest.

The Trustee for the Society's Plan remains the Wachovia Bank & Trust Company, N.A.

Robert W. Williams, M.D., Chairman

#### COMMITTEE ON SOCIAL SERVICES PROGRAMS

The Committee on Social Services programs is concerned about the Social Services Programs both from the overall perspective of adequate legislative funding for programs undertaken and from the day-to-day perspective of reducing unnecessary trauma to physicians who attempt to cooperate with the program.



First from the larger perspective of adequate funding for programs undertaken (especially Medicaid), we have sought to work with the legislative Committee of the North Carolina Medical Society as its attempts to influence the Legislative Study Committee on Cost Containment of the North Carolina House and Senate. Specifically, we believe that increasing Medicaid payments to a reasonable level will accomplish both better health care for recipients and a decrease in total health care expenditures. The decrease in total health care expenditures would be effected through providing a medical home for a patient, decreasing fragmentation and duplication of services plugging the patient into a medical information system (e.g. physicians' office), reducing emergency room and crisis care visits and also reducing chronic illness. The committee has requested the aid of the entire North Carolina Medical Society to discuss these points with individual legislators on a one-to-one basis, especially those legislators who are members of the Legislative Study Committee on Cost Containment.

Second, the committee was disturbed by unnecessary trauma to physicians who have attempted to work with the Medicaid program. With this goal in mind the following resolutions were passed:

- 1) To increase Medicaid fees to 100% of the 75th percentile based on the *previous twelve months data*.
- 2) To expedite enrollment in Medicaid by having a WATS line information service for certification numbers and family numbers.
- 3) To change registration procedures so that newborn babies born near the end of a month can be covered.
- 4) To have the North Carolina Medical Society inform physicians of the correct method for filing CPT codes.
- 5) To call the attention of the Secretary of the Department of Human Resources and the Legislative Study Commission on Cost Containment to the serious alienation of physicians who have attempted to co-operate with the Medicaid program. Continued erosion of physician support can only result in more expensive, emergency and crisis-oriented care for Medicaid recipients. In addition inadequate Medicaid fees will serve to increase the problems of physician maldistribution by discouraging physicians from settling in areas with large numbers of economically disadvantaged patients.

The committee on Social Services seeks the aid of all North Carolina physicians in bringing the above points home to legislators, bureaucrats, consumers, taxpayers, social service workers, and Medicaid recipients.

E. Stephen Edwards, M.D., Chairman

#### COMMITTEE ON TRAFFIC SAFETY

Since I have only been Chairman of the Traffic Safety Committee for a few months, the report will necessarily be limited as it is the result of only one meeting.

Under Dr. Beddingfield's direction, the Committee has done a very fine job, especially in the area of medical review panels. Mr. Douglas Wooten, Mr. Ray Dean, Mr. Elbert Peters, and Dr. Fred Patterson have worked together in implementing this. This is continuing to be a most helpful physician input to prevent people from driving, who for medical reasons, might endanger the lives of others.

The meeting in January of 1978 was a very lively and instructive one with Mr. Forrest M. Council from the University of North Carolina Highway Safety Research Center presenting a very fine report on child restraints in automobiles. The Committee felt this should be endorsed by

the Medical Society and appropriate steps were taken to suggest this.

Mr. Earl Griffith, Assistant Secretary for Alcohol and Drug Abuse of the Department of Human Resources, gave a very fine report on the relationship of alcohol to traffic safety. He gave some suggestions on how we might better prevent driving under the influence in North Carolina. The Committee endorsed Mr. Griffith's work and will attempt to elicit the support of physicians throughout the state of North Carolina to educate the public on the hazards of alcohol.

George Johnson, Jr., M.D., Chairman

#### REPORT TO THE NORTH CAROLINA MEDICAL SOCIETY BY THE PHYSICIAN TRUSTEES OF BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

The Physician Trustees of Blue Cross and Blue Shield of North Carolina have actively participated in all activities of the Board of Trustees. Attendance has been excellent at Board meetings and physicians have participated in committee work and other Board functions.

Blue Cross and Blue Shield of North Carolina ranked first among all Blue Shield Plans in the nation in its peer group (one million subscribers or more) in meeting or exceeding National Performance Standards based on amount of time required to issue identification cards, respond to inquiries, and process claims. Blue Cross and Blue Shield of North Carolina has grown to be the 10th largest Blue Shield Plan and the 11th largest Blue Cross Plan in the nation and has approximately two million participants. The Plan processed more than 2.7 million regular Blue Cross and Blue Shield claims with dollar benefit payments exceeding \$306 million in 1977. Total benefits paid through all underwritten and administered programs were \$637 million. Administrative expenses were 5.8 percent of income.

Plan President Thomas A. Rose and State Treasurer Harlan E. Boyles renewed the \$80 million contract with the State to administer and underwrite health benefits for approximately 410,000 North Carolinians, including active and retired school teachers and state employees, their dependents, and for the first time this year current and former state legislators and their surviving spouses. Blue Cross and Blue Shield of North Carolina began administering and underwriting the state employees program on July 1, 1972; since then, the Plan has paid out \$204 million for health care services for state employees.

Plan Medical Director William J. A. DeMaria, M.D., organized and directed a Health Education and Screening Program for Blue Cross and Blue Shield employees to learn about disease detection and to be screened for diabetes, high blood pressure, and cancer of the cervix, colon, breast, prostate, bladder and mouth. The program was conducted by Seigfried Heyden, M.D., Professor of Community Health Services at Duke University Medical Center. Of those who participated, 70 women and 14 men were referred to their physicians for medical evaluation of a potential health problem.

With the approval of Governor Hunt and his Cabinet this model is being applied to a test group of 10,000 state employees in three counties. The Medical Societies of these three counties, Burke, Pitt and Wayne, have given unanimous approval of this test project.

Sandra Greene, Dr. P. H., joined the Plan in November as Director of the new Office of Health Economics Research. Her primary function will be to develop and implement a

health economics research program focusing mainly on cost containment. In addition to coordinating all external health care cost containment activities, Dr. Greene will coordinate internal cost containment programs.

Continuing participating as "invited representatives" were Dr. John W. Foust, Chairman of the Blue Shield Committee, and Dr. D. E. Ward, Jr., President-Elect of the North Carolina Medical Society. Blue Cross and Blue Shield of North Carolina continues to be responsive to the needs of the people of North Carolina. The Physician Trustees believe this responsiveness is fostered through the close cooperation between public, hospital and physician members of the Board of Trustees.

Roy S. Bigham, Jr., M.D.  
 Frederick A. Blount, M.D.  
 James E. Davis, M.D.  
 H. Fleming Fuller, M.D.  
 Marvin N. Lymberis, M.D.  
 Kenneth D. Weeks, M.D.

#### NORTH CAROLINA BOARD OF MEDICAL EXAMINERS STATISTICS AND ANNUAL REPORT

November 1, 1976 — October 31, 1977

Total number of applicants granted license:	960
By endorsement of credentials:	729
By written examination (FLEX):	231
Examination failures (FLEX):	90
Limited licenses:	143
Counties:	142
State institutions:	1
Resident's training licenses:	468
Applicants rejected license by endorsement — did not meet Board requirements:	6
Applicants declined permission to take examination:	0
License to practice medicine revoked (one case on appeal):	4
License to practice medicine revoked: revocation stayed:	3
License to practice medicine suspended: suspension stayed:	1
License to practice medicine voluntarily surrendered:	2
License to practice medicine reinstated:	1

#### NORTH CAROLINA MEDICAL CARE COMMISSION

Report on Activities for the Calendar Year Ending  
 December 31, 1977

##### Medical Facility Planning and Construction

The latest State Plan for the Construction of Hospitals and Medical Facilities adopted by the Commission indicates that the need for additional hospital beds in North Carolina has been essentially met until 1982. The Plan forecasts that approximately 2,668 general hospital beds will need to be modernized to some degree within the next five years.

During 1977, the Commission approved the issuance of tax-exempt revenue bonds under the Health Care Facilities Finance Act for four projects totaling approximately \$60 million and is working with four additional projects that will require nearly \$100 million. This program provides a financing vehicle whereby hospitals may undertake capital financing at a relatively low cost and, ultimately, hold down the cost of medical care to its patients.

#### Educational Loan Program

Recipients of the Commission's educational loans agree upon completion of their training to repay their loans by one calendar year of service for each year they received funds. During 1977, 209 students were working in qualifying practice sites and 249 new applicants representing twenty health-related disciplines were approved for funding; the number of loan agreements renewed was 261. The total amount of State funds used in financing these students was \$1,423,989.81. The total number of students receiving financial assistance from the Commission since the 1945 General Assembly created the program is 3,530.

In December, 1977, the Commission approved increase in the maximum loan amounts for Master's degrees, Bachelor's degrees, certificate programs, and Associate degrees in seventeen disciplines. The loan amounts for some of these areas had not been increased since 1965.

#### Licensure and Certification

The Commission has responsibility for promulgating rules and regulations for the Licensure of hospitals and for the certification of abortion clinics. In 1977, there were 14 hospitals containing 23,448 beds licensed under regulation adopted by the Commission pursuant to General Statute 131, Article 13A. These 143 hospitals included 130 acute care hospitals and 13 specialty hospitals.

At the end of 1977, there were 15 certified abortion clinics. The number of abortion clinics has stabilized for the most part; thus no great increases are expected.

#### Emergency Medical Services

The training of personnel to provide better prehospital care remained a primary goal of the Emergency Medical Services program in 1977. During the year, 4,800 persons were certified as emergency medical technicians, bringing to 17,800 the total number of EMTs certified since the Emergency Medical Services Act of 1973 became effective.

I. O. Wilkerson, Jr., Director

#### EDITORIAL BOARD

##### North Carolina Medical Journal

The Editorial Board met twice during the past year on May 7 and September 24, 1977.

The Board is concerned with many problems including original articles, editorials, correspondence, the Bulletin Board (which includes a calendar of events, reports of the auxiliary, news notes from the principle medical centers, and correspondence from other medical organizations), legislative notes from Washington, book reviews, and not the least advertising. At each of the two meetings during the year the above topics were discussed.

At the last accounting the actual costs of 12 monthly issues, including postage, was \$65,527.88. With the Roster included the cost was \$89,606.05. Roster and Journal sales income was \$6,056.29 and advertising income was \$29,101.98. The actual average cost of the Journal per dues paying member was \$11.83. Life Members plus exempt members totaling 377 receive the Journal as an emolument of such membership.

The cost of Journal advertising has not increased since 1976 but anticipated increase is scheduled for 1979.

During the past year 61 papers have been received for publication and there is a backlog of unpublished papers which gives about an eight months supply.



The Board passed the following Motion: The number of Elective Members of The Editorial Board, as provided in the By-laws, be increased to eight. This motion was passed in order to comply with the By-laws of the Society, Chapter V, Section 5, d which reads as follows: "The Editorial Board shall contain at least one member of the faculty of each of the schools of medicine within the State." The motion would thus allow an Editorial Board member from East Carolina University School of Medicine.

By action of the Board a disclaimer is to be printed in the Mast Head of the Journal as follows: The appearance of an

Advertisement in this Publication Does Not Constitute Any Endorsement of the Subject or Claims of the Advertisements.

The Journal welcomes letters to the Editor for publication, letters of inquiry, and letters of information. The Board invites the membership to take advantage of this avenue for membership opinion.

Charles W. Styron, M.D., Chairman  
Editorial Board  
North Carolina Medical Journal

# 1978 TRANSACTIONS

## Executive Council

### Summary of Minutes of Meetings of the Executive Council

**NOTE:** As recommended by the Finance Committee, the Executive Council authorized that just the salient actions of the Executive Council will be reported in brief form.

The verbatim transcript of the Executive Council minutes are on file in the Headquarters Office and may be reviewed or pertinent portions excerpted on request.

#### FALL EXECUTIVE COUNCIL MEETING

September 25, 1977

##### (Morning Session)

—The Fall Meeting of the Executive Council convened at 9:00 a.m. in the Meeting House, Mid Pines Club, Southern Pines, N.C., President E. Harvey Estes, Jr., M.D., presiding. Dr. John Glasson gave the invocation and the Secretary, Dr. Jack Hughes, after checking the roll declared a quorum present.

—Dr. David G. Welton, AMA Delegate, was recognized to pay tribute to the late Dr. Edgar T. Beddingfield, Jr., noting that he would be sorely missed as a member of the North Carolina Delegation to the AMA by this Society and by all the other organizations and groups to which he has contributed so much. Dr. Welton also reminded the Council of other grievous losses among the N.C. AMA Delegation in recent years: Elias Faison in 1969; Frank Jones in 1973; Donald Koonce and Amos Johnson in 1975. The Council observed a few moments of silent prayer in honor of all of them.

—Mrs. Robert (Mary Leila) Andrews, President, Auxiliary to the North Carolina Medical Society, presented a brief report of the Auxiliary activities of the year. She noted that Auxiliary membership was at an all time high of 3,032 and 33 members at large. This year's state theme is "Total Health for the Total Family."

—The Executive Council unanimously approved a resolution from the Wilson County Medical Society that the 1978 Conference for Medical Leadership planned for February be held in memory of and dedicated to the late Dr. Edgar T. Beddingfield, Jr.

—Dr. John Glasson, Chairman, Mediation Committee reported the Committee continues active with a gradual increasing of cases for consideration. He indicated he felt the Committee continues to serve the people of the State and the Medical Society a useful function in trying to resolve the differences that arise, largely in the area of the relationship between doctor and patient and sometimes the relationship between doctors.

—The Council on Review & Development reported that it had considered a recommendation of the Committee on Awards that it be abolished feeling its work could be done by the Committee on Arrangements. The Executive Council approved a motion, on the recommendation of the Council on Review and Development that the Committee on Awards be abolished. See separate REPORT C — REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 50, HOUSE OF DELEGATES, May 4, 1978.

—The Council on Review and Development concurred in a recommendation from the Committee Advisory to the

Auxiliary that the Executive Council consider formulation of a policy that members of the North Carolina Medical Society not be paid an honorarium for participation in functions of the Society and its Auxiliary; that expenses may be paid by policy in existence of the Medical Society. The Executive Council approved a motion in keeping with the recommendation.

—Dr. J. Jerome Pence, Secretary, North Carolina Board of Medical Examiners, reported briefly on the activities of the Board and that the Board continues to meet approximately every five weeks. He noted that Dr. David Citron had been invited to address the Federation of State Medical Boards in Chicago in February.

—Dr. T. Tilghman Herring, Chairman, Committee on Finance, presented the proposed Budget for 1978. The Finance Committee also requested approval not to place the five percent of the operating budget in the Reserve Fund in order to present a balanced budget, but with the hope that the five percent to the Reserve Fund could be restored by the end of the year. The Executive Council approved the budget as proposed. See separate REPORT A — REPORT OF THE EXECUTIVE COUNCIL, Page 52, HOUSE OF DELEGATES, May 4, 1978.

—The Committee on Finance requested the Executive Council to establish a policy with regard to payment of expenses for Commissioners attending Council meetings. After discussion the Executive Council approved a motion that the expenses of the ex-officio members of the Council be paid relative to Executive Council meetings and business, except where their expenses are paid by other sources.

—Dr. Louis deS. Shaffner was named by the Executive Council as a Delegate to the AMA, to fill the unexpired term of the late Dr. Edgar T. Beddingfield, Jr., to serve until the next meeting of the House of Delegates.

—Dr. E. Harvey Estes, Jr., was named by the Executive Council as an Alternate Delegate to the AMA, to fill the unexpired term of Dr. Louis deS. Shaffner, such term runs to December 31, 1978.

—The Executive Council unanimously approved a motion to endorse Dr. Eben Alexander for nomination for a position on the AMA Council on Medical Education.

—The Executive Council approved a motion to endorse North Carolina Medical Society of AMA Committees or Councils as follows: Dr. Archie T. Johnson, Jr., for appointment to the proposed ad hoc Committee on Health Planning; Dr. C. Douglas Maynard for appointment to the Residency Review Committee for Nuclear Medicine; and Dr. Joseph A. C. Wadsworth for appointment to the Advisory Council for Ophthalmic Surgery.



—The Committee on Medical Education reported that it was recommending the establishment of a subcommittee for the purpose of effecting a transition from the present society continuing Medical Education requirements to the AMA Physician Recognition Award requirements and that the Committee would likely recommend the North Carolina Medical Society adopt the AMA-PRA requirements for its CME accreditation. The Committee also reported it was recommending that any hospital audit actively should be credited hour for hour under Category "B" for the Society CME requirements.

—The Committee on Arrangements recommended and the Executive Council approved omitting the golf and tennis tournament for at least one year.

—The Committee on Social Services Programs presented a recommendation, in the form of a resolution, with regard to the level of Medicaid payments. After considerable discussion and amendment, the Council approved the resolved portion "That the North Carolina Medical Society supports payment of one hundred percent of the level allowable by the HEW based on the previous twelve months data." See separate REPORT B — REPORT OF THE EXECUTIVE COUNCIL, Page 55, HOUSE OF DELEGATES, May 4, 1978.

—The Committee on Social Services Programs recommended and the Executive Council approved two resolves: (1) that the Secretary of the Department of Human Resources of North Carolina be requested not to require a stamp as the only way a Medicaid claim can be processed; and (2) that EDS-Federal (the present payor) continue with a WATS line information service regarding certification numbers and family numbers for eligible patients to expedite claims processing.

—The Committee on Social Services Programs recommended and the Executive Council approved that the Secretary of the Department of Human Resources be reminded of the grossly unfair manner in which current procedure of enrolling newborn babies in the Medicaid program discriminates against physicians who care for babies born near the end of the month; and that if this discrimination emanates from federal guidelines beyond the control of the Secretary, that she be petitioned to demand redress from HEW.

—On recommendation of the Committee on Social Services Programs, the Executive Council approved a motion that the North Carolina Medical Society have emissaries contact each legislator on the Legislative Study Commission to acquaint him with the disastrous course in which the Medicaid programs are now headed.

—The Committee on Social Services Programs recommended and the Executive Council approved a motion that the Society inform physicians of the correct methods of filing CPT codes in order to be able to obtain proper compensation for services rendered.

#### (Afternoon Session)

—The Executive Council considered a recommendation from the Committee on Professional Insurance concerning society approval for an Officer Protector Plan of insurance which would offer a variety of types of insurance protection such as premises liability, personal liability, workmen's compensation, bonding requirements of the ERISA reform act of 1974, etc. However, the Council postponed indefinitely until the next meeting of the Executive Council.

—The Executive Council approved a motion that a review by the Executive Council be made at its next meeting on the policy of approval of various items which may be offered to this Society for sale to its membership.

—The Council approved a recommendation from the

Editorial Board of the *North Carolina Medical Journal*, presented through the Committee on Constitution and Bylaws, that a change in the bylaws be made to increase the number of members on the board to eight instead of seven. See separate REPORT C — REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 50, HOUSE OF DELEGATES, May 4, 1978.

—The Committee on Medical Cost Containment made a series of five recommendations, which were approved by the Executive Council, as follows:

1. The Legislative Study Commission on Medical Cost Containment investigate a method to provide reimbursement for home custodial care for eligible and suitably approved patients as an alternative to care in an ICF.
2. The Legislative Study Commission on Medical Cost Containment seek financial support from federal, state or other sources for a pilot program to demonstrate the practicality and cost savings from the provision of financial aid and personal services in the home as an alternative to ICF care.
3. The Legislative Study Commission on Medical Cost Containment examine other state Medicaid programs (such as Virginia) which have successful eligibility determination programs.
4. The Legislative Study Commission on Medical Cost Containment recommend the development of procedures to permit dual certification of SNF beds to allow reimbursement for ICF care when such care is the level of care provided.
5. The Legislative Study Commission on Medical Cost Containment recommend establishment of a reimbursement structure whereby acute care hospitals would be paid at the SNF or ICF rate in those instances where it is determined that acute care is or was not necessary but SNF or ICF care was needed.

—The Committee on Medical Cost Containment recommended and the Executive Council approved in principle the following statement and, within budget limitations, authorized its implementation by the Committee:

"In order to increase physician awareness of medical care costs, samples of patients' bills should be submitted to each attending physician at monthly or other appropriate intervals. A listing of the various costs of drugs, laboratory, diagnostic, therapeutic and other ancillary services should be posted in physician work areas in hospitals."

—The Executive Council postponed until a later meeting, consideration of a recommendation from the Committee on Maternal Health that the Society go on record as recommending repeal of the regulatory statute which allows the Department of Human Resources, Division of Health Services, to license untrained lay people for the purpose of obstetrical delivery.

—The Committee on Maternal Health recommended, and the Executive Council approved that the North Carolina Medical Society go on record opposing the Department of Health, Education and Welfare elimination of payments for abortions to the poor and indigent. That the Medical Society actively seek to influence the Legislature of North Carolina to make funds available for abortions to the poor and indigent. See separate REPORT D — REPORT OF THE EXECUTIVE COUNCIL, Page 56, HOUSE OF DELEGATES, May 4, 1978.

—The Committee on Marriage Counselling and Family Life Education recommended, and the Executive Council approved, that the Society write a formal letter to the

Superintendent of Public Instruction stating:

1. The Society supports the teaching of sex education in a broad sense of the word in the public schools of North Carolina.
2. Members of the Society would be willing, if asked, to participate in in-service education for teachers in order to expand the teacher's knowledge of sexual function and family life.

—The Executive Council approved a recommendation from the Committee on Mental Health that the Society endorse the efforts of the Division of Mental Health and pledges the support of the medical community to achieve the Goals of:

1. the community support program
2. the quality assurance program
3. the continuing education
4. get greater immediate involvement of the private sector of psychiatric practice.

—A recommendation from the Committee on Mental Health, concerning responsibilities for providing mental health services to the Department of Corrections' population, was postponed indefinitely until the next meeting of the Executive Council.

—The Executive Council approved a recommendation, from the Committee on Mental Health, that the ad hoc committee entitled "Troubled Medical Provider" be replaced by a continuing committee entitled Physicians' Health and Effectiveness Committee under the Public Service Commission.

—The Committee on Drug Abuse recommended, and the Executive Council approved, that Talwin injectible form be placed under controlled substances on Schedule IV.

—The Executive Council approved a recommendation, from the Committee on Drug Abuse, that the North Carolina Medical Society inform all physicians in the state of the problem of patients receiving mind altering drugs from V.A. facilities without frequent face to face contact between physician and patient.

—The Executive Council tabled a recommendation from the Committee on Child Health that routine screening of newborns for hypothyroidism be established as a part of the newborn screening program.

—On recommendation of the Medical-Legal Committee, the Executive Council approved a motion to ask the Medical Liability Mutual Insurance Company to consider the problems of punitive damages and if not already covered, (study) the feasibility of insuring against this contingency.

—The Committee on Eye Care and Eye Bank recommended a restatement of the guidelines for the ethical practice of ophthalmology and to recommend the guidelines

enforcement to the Board of Medical Examiners. The Committee further requested that a copy of the guidelines be mailed by the Medical Society headquarters to all ophthalmologists practicing in North Carolina.

—The Executive Council approved a Committee on Eye Care and Eye Bank request that it be noted in the President's Newsletter that:

It is the opinion of legal counsel that the word "collaboration" means responsible participation in the diagnosis and treatment of the patient.

Also there will be a letter sent to the President of each county society defining the word "collaboration." And further a letter sent to each member of the Society including this same information with special notation on the outside of the envelope.

—After making slight changes in a recommendation from the Committee on Eye Care and Eye Bank, the Executive Council approved that the Executive Council do all within its power to advise the North Carolina delegates to the American Medical Association to see that a physician licensed to practice medicine be the primary provider of eye care.

—The Executive Council referred a recommendation from the Committee on Community Medical Care, to the Committee on Legislation to the effect that the Society actively seek appropriate legislation to adequately regulate the operation of multiphasic health testing services.

—At the request of the Committee on Communications, the Executive Council approved two recommendations as follows:

1. Sending a commendation to the Bowman Gray School of Medicine for their series of Medical Practice Seminars; and
2. That the medical schools expand geriatric training, pointing out the fact that there is a great deficit in this area and a real need for formalizing training for geriatric physicians.

—The Executive Council approved a recommendation from the Committee on Communications that the Society recognizes the acute need for cadaver donors to meet the health care requirements of the citizens with end-stage renal disease and recommends participation in community hospital kidney procurement programs in conjunction with the transplant centers to procure kidneys for transplantation.

—The Executive Council, on recommendation from the North Carolina MedPac Board of Directors, named Dr. Lawrence M. Cutchin of Tarboro to the unexpired term of the late Dr. E. T. Beddingfield, Jr., on the North Carolina MedPac Board of Directors.

## MID-WINTER EXECUTIVE COUNCIL MEETING

February 5, 1978

### (Morning Session)

—The Mid-Winter meeting of the Executive Council of the North Carolina Medical Society convened at 9:10 a.m. in the Executive Council Room of the Medical Society Building, Raleigh, N.C., President E. Harvey Estes, Jr., M.D., presiding. Immediate Past President Jesse Caldwell, Jr., M.D., pronounced the invocation and Secretary Jack Hughes, M.D., checked the roll and declared a quorum present.

—The Chairman of the Committee on Finance, Dr. T. Tilghman Herring, reported as information of the Society reserved fund had reached a level of \$403,409.31. He also

advised the Council that an option to purchase the remainder of the Society property on Highway 70 West has been exercised with annual payments for purchase of the property extending over a fifteen year period plus eight per cent interest on the unpaid amount.

—John S. Rhodes, M.D., of Raleigh was named to fill the unexpired term of the late Oscar L. Sapp, III, M.D., on the Committee on Nominations representing the Sixth District, a term running to May 1978.

—The Chairman of the Committee on Legislation, Dr. Archie T. Johnson, Jr., reported on the status of the Comprehensive Health Education Bill (H.B. 540) in the N.C.



General Assembly, which has been pushed by the Medical Auxiliary, as having been adopted but not funded. There is hope, he indicated, for the funding of the bill. Dr. Johnson advised that the 1978 session of the General Assembly will be primarily to discuss budgetary matters so that the Society will have only a small number of items to come before this General Assembly. There are, however, items on the agenda concerning Medicaid, the Commission on Cost Containment, as well as a bill pertaining to the acts permitted by nurse practitioners and physician's assistants. No formal action was taken by the Council, but the general consensus was to authorize the Committee on Legislation and the staff, and officers, to proceed with discussions and negotiations with representatives of the Nurses' Association in preparing a bill for proposal to the General Assembly.

—The Chairman of the Committee on Constitution and Bylaws advised the Executive Council that the bylaws do not speak the question of whether a member serving out an unexpired term of another member would be eligible for re-election to that office at the next meeting of the House of Delegates. The Executive Council approved a motion recommending changing the bylaws to the effect that a member serving out an unexpired term of another member shall be eligible for re-election to that office.

—The Executive Council postponed indefinitely the consideration of the Office Protector Plan Insurance proposal offered by the J. L. & J. Slade Crumpton Insurance Agency.

—The Executive Council postponed indefinitely any review of the Society policy of approval of various items offered to the Society, such as Society Approved insurance programs.

—On recommendation from the Committee on Traffic Safety, presented by Dr. T. Reginald Harris, Chairman of the Advisory and Study Commission, the Executive Council approved a resolution that: "The Committee on Traffic Safety recommends to the Executive Council that the North Carolina Medical Society go on record supporting the use of approved automobile child restraints for children ages one to five." See separate REPORT E — REPORT OF THE EXECUTIVE COUNCIL, Page 56, HOUSE OF DELEGATES, May 4, 1978.

—On recommendation from the Committee on Mental Health, the Executive Council approved the Memorandum of Understanding between the Department of Corrections and the Department of Human Resources primarily designed to improve the care of the patients in the Department of Corrections.

—The Executive Council approved a motion that the Executive Council express through Dr. Philip Nelson's Commission that mentally ill patients be evaluated for institutional commitment for medical and treatment reasons as well as their potential of being dangerous to themselves or others.

—Dr. John Glasson, Chairman, Mediation Committee, reported as information that during the year the committee had considered some 43 cases, of which 16 did not involve any improper conduct on the part of the physician. Of the total 31 have been closed, two have been considered extensively and remain open for further investigation. Ten cases are rather recent and are still in the process of investigation.

—The Council referred to the Mediation Committee for their recommendation as to what the Society should do concerning responsibility of the Society to study and advise

on issues between the public and physicians not members of the Society.

#### (Afternoon Session)

—Dr. Daniel Gottovi presented a brief description of the purposes and objectives of Hospice of North Carolina, Inc., explaining there are many situations where patient and family with proper emotional and nursing support might prefer to have their final days at home or in a less rigid institutional setting. The program would also attempt to aid patients and their families in the transition from hospital care to home care and back again when needed. They would provide counselling in the areas of death and dying for patient and family when appropriate to supplement services provided by the family clergy and physician. A well-developed and functioning hospice program, said Dr. Gottovi, would offer the physician an additional alternative for care at a time when increasing home health care services will be greatly needed. The Executive Council passed a motion approving the hospice concept in North Carolina.

—The Executive Council approved an interpretation of County Society membership, as of December 1, for purposes of Delegate entitlement to be that "membership shall be counted as those dues paying members (including those deceased after payment of dues) plus those exempt from dues who are still living."

—A motion was passed by the Executive Council that the question of whether or not to invite non-member guests to attend the Executive Council meetings be left to the discretion of the Executive Committee of the Council on an individual basis.

—The Executive Council voted to reconsider an action it took, in executive session, at the Council meeting on September 25, 1977, which "Resolved that the Executive Council of the North Carolina Medical Society go on record as opposing the deliverance of primary health care through county public health departments and recommends that previously appropriated funds be routed to the Rural Health Programs and other incentive programs for primary health care." After considerable discussion, plus an executive session, an action was approved in the executive session summarized for the record by President Estes as follows:

"This motion was made that the Executive Committee of the Executive Council be empowered to write a position paper on the matter of primary care clinics (in County Public Health Departments) expressing the concerns of the Executive Council and amplifying those concerns, and this position paper to be brought up to the Council in February (16th) when we're all in Charlotte at the Joint Meeting with the North Carolina Hospital Association."

—The Committee on Medical Education recommended an extension to those physicians who had not completed their continuing medical education requirements and the Executive Council approved a motion that those physicians who had not completed the requirement be given until the end of the year (December 31, 1978) to complete their requirements.

—The Executive Council voted to continue its membership in the North Carolina Health Council.

—President Estes announced that the next regular meeting of the Executive Council would be held on April 16, 1978, in Raleigh at the Medical Society Building.

## ANNUAL EXECUTIVE COUNCIL MEETING

April 16, 1978

## (Morning Session)

—The Annual Meeting of the Executive Council convened at approximately 9:00 a.m. in the Executive Council Room of the Medical Society Building, Raleigh, N.C., President E. Harvey Estes, Jr., M.D., presiding. President-Elect D. E. Ward, Jr., M.D., gave the invocation. The Secretary, Jack Hughes, M.D., checked the roll and declared a quorum present.

—The Chairman of the Mediation Committee, Dr. John Glasson, reported as information that the committee during the past year had considered 18 cases, most of which had been resolved satisfactorily. He indicated there had been one special case involving the utilization of medical services and the pattern of practice of a fairly new member of the Society. Upon learning of the consideration by the Mediation Committee, the member had resigned and requested no further involvement of the Committee and expressing through his Attorney the fact that most of the incidents in question transpired prior to his Society membership.

—The Chairman of the Committee on Constitution and Bylaws submitted a proposed amendment to the Bylaws as an editorial change for ease in understanding for one section, Chapter V, Section 1, which changes one sentence in the body of the section without changing any intent of the provision. See separate SUPPLEMENTARY REPORT C — REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS, Page 50, HOUSE OF DELEGATES, May 4, 1978.

—Without taking any formal action, the Executive Council reviewed the Position Paper Regarding Primary Care in County Health Departments and the response to the position paper received from the Director of the Division of Health Services, Dr. Jacob Koomen.

—The Secretary of the Board of Medical Examiners, Dr. Charles B. Wilkerson, Jr., reported briefly on the activities of the Board with statistics regarding granting of licenses to practice medicine in North Carolina and license revocations or suspensions. The details are contained in the Report of the Board of Medical Examiners found in the Compilation of Annual Reports. He also related that the cost of obtaining the FLEX examination from the Federation of Licensing Boards was recently increased sharply and requested that the Society take under consideration support for a legislative change which would permit the Board to charge \$100 for Examination and \$100 for Licensure. The Board now charges \$100 for Examination and Licensure. Following discussion, the Executive Council approved a motion "That the North Carolina Medical Society recommends that the General Statutes of North Carolina be amended to authorize the Board of Medical Examiners to charge a fee not to exceed \$200 for the issuance of a license to practice medicine by examination as provided in G.S. 90-15." See separate REPORT F — REPORT OF THE EXECUTIVE COUNCIL, Page 56, HOUSE OF DELEGATES, May 4, 1978.

—Dr. Archie T. Johnson, Jr., Chairman of the Committee on Legislation gave a brief summary of national legislative issues and also made reference to some state legislative items which might come before the next session of the North Carolina General Assembly.

—The Executive Council considered recommendations for implementation of a Voluntary Cost Containment Program in North Carolina as a joint project between the North Carolina Medical Society and the North Carolina Hospital

Association. Following discussion, the Council adopted a motion endorsing the concept of the recommendations for implementation, but included in its motion sentiment in favor of broadening the public representation in the implementation. Approval was also recommended for financial support up to \$7,500. See separate REPORT G — REPORT OF THE EXECUTIVE COUNCIL, Page 56, HOUSE OF DELEGATES, May 4, 1978.

—Nominees for the 1978-1979 North Carolina MEDPAC Board of Directors were received and the following were elected:

Kenneth E. Cosgrove, M.D.	John L. McCain, M.D.
John T. Dees, M.D.	David S. Nelson, M.D.
James E. Davis, M.D.	Marshall S. Redding, M.D.
T. Reginald Harris, M.D.	Robert H. Shackelford, M.D.
Charles A. Hoffman, Jr., M.D.	J. David Stratton, M.D.
William F. Hollister, M.D.	Shahane R. Taylor, Jr., M.D.
Archie T. Johnson, Jr., M.D.	John W. Watson, M.D.

*Auxiliary:* Mrs. Jackie Stallings  
Edna Hoffman, M.D.

—The Executive Council reviewed a proposal, submitted by Dr. William J. Demaria as Medical Director of Blue Cross & Blue Shield of North Carolina, identified as Selected Education and Screening for Employees (SEASE). Following discussion, the Council accepted the proposal as information, but requested that the President of the Society convey to Dr. Demaria in writing the feeling of the Council that the proposal should be cleared with the appropriate County Medical Society at each proposed location before implementation.

—The Executive Council reviewed a brief description of each of the so-called Society approved insurance plans offered to the membership and approved a motion that the descriptions be received as information.

—The Council also again considered the recommendation from the Committee on Professional Insurance regarding approval of the so-called Office Protector Plan or the TOP plan, but upon reconsideration the Executive Council voted that the subject be referred back to the Committee on Professional Insurance for reconsideration in the light of recent developments.

—The Executive Council reviewed information about the proposed development of a Health Care Data Consortium then voted to receive it as information and authorized continued discussion with the organizations proposing a Health Care Data Consortium but without any authorization to participate in such a data consortium.

—President Estes advised the Council, as information, of the appointment of an ad hoc Committee to Look at Peer Review Activities of the North Carolina Medical Society. He related that the N.C. Medical Peer Review Foundation Board had requested that the Medical Society consider the matter of Peer Review activities of the Society with the objective of constructing a more unified and more cohesive approach to this activity.

—Dr. David G. Welton, Senior N.C. Delegate to the AMA presented a brief informational report on "The AMA in 1977." He proposed that the report be made available to the Society membership in the near future. The report reviewed several areas of interest including Finance, Membership, the National Commission on the Cost of Medical



Care, Legislation, and Scientific and Educational Activities as well as several other items.

#### (Afternoon Session)

—A Resolution from the Forsyth-Stokes-Davie County Medical Society was received as a late resolution and accepted for referral by the Executive Council to the House of Delegates for consideration. See separate RESOLUTION: 15—RESOLUTION INTRODUCED BY FORSYTH-STOKES-DAVIE COUNTY MEDICAL SOCIETY, Page 61, HOUSE OF DELEGATES, May 4, 1978. At the same time, the Executive Council authorized the Executive Director to send a copy of any late resolutions to the Delegates as information, but to so label them as LATE RESOLUTIONS.

—The Council reviewed the lettered reports "A" through "E" as contained in the delegates' materials which were accepted for referral to the House of Delegates, and for referral to the Reference Committees assigned by the Speaker, all having been developed on the basis of previous Council actions.

—The Council reviewed numbered Resolutions 1 through 14 for referral to the Reference Committees to which assigned by the Speaker.

—Consideration was given to the Continuing Medical Education requirement for Life Members, with the Executive Council approving a motion granting present Life Members exemption from the CME requirements for continued membership, but that future Life Members be required to meet the CME requirements so long as they are still seeing patients.

—Upon reconsideration of the Committee on Maternal Health recommendations regarding Licensing of Lay Midwives, the subject having been delayed from a previous Council meeting, the subject was referred to the Committee on Legislation with the request that the Committee frame a resolution which should be brought back to the Executive Council for implementation.

—An appeal was presented from the North Carolina Department of Cultural Resources, Division of Archives and History for financial support to the extent of \$4,000 to purchase the last World War II, United States Army hospital car known to exist in its original configuration. The car is proposed for location at the State's developing historic site in Spencer, N.C., where the Southern Railway Company Shops will be preserved as a historic site for the preservation of North Carolina's transportation history. The Executive Council voted to endorse the project and to put an item in the Society BULLETIN inviting contributions toward the purchase of the rail car.

—The Executive Council approved a motion that Major Peter G. Chikes, M.D., MC, U.S. Army, who was a Resident member of the North Carolina Medical Society until his entry into military service, be given membership in the Society under the military dues exempt provisions.

—Approval was given for the Executive Director to attempt to arrange group travel for Society members and the N.C. AMA Delegation, through the AMA designated travel

agent, for attendance at the AMA Interim Meeting in Hawaii in December of 1979.

—On request of the Chairman of the Committee on Communications, Dr. John L. McCain, the Council approved a motion approving the plans as presented by Dr. McCain outlining the proposed participation of District Councilors and Society officers in the 1979 Conference on Medical Leadership.

—On recommendation of the Chairman of the Committee on Communications adopted a resolution of appreciation to Burroughs-Wellcome for their assistance as follows: "Because of the great assistance and leadership provided by Burroughs-Wellcome for improving communications with the public, the North Carolina Medical Society Executive Council formally expresses our appreciation to Burroughs-Wellcome and Company, Mr. Fred Coe, President, Dr. S. Winston Singleton, Medical Director, and Mr. Dave Reynolds, Consultant."

—The Chairman of the Committee on Communications presented a Draft of a Statement on Death and Dying which the Executive Council referred to the Committee on Chronic Illness for further study and recommendations back to the Council.

—A Resolution on Obesity submitted by the Chairman from the Committee on Communications was also referred to the Committee on Chronic Illness for further study and recommendations back to the Executive Council.

—A request from the Committee on Mental Health for co-sponsoring a dinner for legislators, and physicians with the North Carolina Alcoholism Research Authority during Alcoholic Awareness Week was defeated.

—The President-Elect, Dr. D. E. Ward, Jr., proposed the possibility of holding a so-called "Think Tank" or discussion meeting for long range planning sometime during the summer months with members of the Executive Council, the AMA Delegates and Alternate Delegates, and the Past Presidents comprising the Council on Long Range Planning and Development to be invited. Several locations were considered including some places outside the continental U.S. The Council, however, favored a location closer to North Carolina and approved the President-Elect exploring locations and dates for such a proposed meeting with the information to be circulated to the Council.

—Just prior to adjournment, Past President, Dr. Jesse Caldwell, presented a resolution of appreciation for Dr. Estes since this was the last Executive Council meeting over which he would preside. The Resolution, unanimously adopted with a standing round of applause, was as follows: "I move that the Executive Council record its appreciation to President E. Harvey Estes, Jr., for his dedicated leadership during the year, compliment him on his calm demeanor in presiding as Chairman of the Council and wish him a gratifying and prosperous career as Past President of the North Carolina Medical Society."

—Before adjournment, President Estes expressed his appreciation to the members of the Executive Council for their cooperation, assistance and time spent on the affairs of the Society and stated that it had been a privilege for him to serve as Chairman of the Executive Council.

# House of Delegates

## FIRST SESSION

### Abridged Minutes of the Meetings of the House of Delegates

#### ANNUAL MEETING—FIRST SESSION

#### THURSDAY AFTERNOON SESSION

May 4, 1978

The First Meeting of the House of Delegates at the 124th Annual Meeting of the North Carolina Medical Society convened at two o'clock in the Cardinal Ballroom of The Pinehurst Hotel, Pinehurst, North Carolina.

DR. E. HARVEY ESTES, JR. [President of the Medical Society]: Good afternoon! The first session of the House of Delegates of the 124th Annual Session of the North Carolina Medical Society is now convened.

It is my pleasure to introduce our distinguished Speaker of the House, Dr. Marvin Lymberis from Charlotte, who will preside over the meeting of the House of Delegates.

Dr. Lymberis tells me this is his thirtieth anniversary as a Medical Society member, and he has provided wise and unselfish leadership to the Medical Society. It is with great pleasure that I turn the Chair over to our Speaker, Dr. Lymberis.

DR. MARVIN N. LYMBERIS [Speaker, House of Delegates of the Medical Society]: Thank you, Mr. President. We will ask Past President, John Glasson, to invoke the blessing upon this House.

DR. JOHN GLASSON [Past President; AMA Delegate of the Medical Society]: May we all bow our heads in prayer!

Our Father, again we thank you for the privilege of meeting together as we consider in concert those matters brought before the House of Delegates of the North Carolina Medical Society.

May we be ever mindful of the best interests of our patients as we make these decisions.

We confess our inability to fulfill our obligations and responsibilities to them without your help. Be with us and guide us in all our deliberations. We ask these things in the name of Thy Son, Jesus Christ, Amen!

SPEAKER LYMBERIS: We have two distinguished visitors with us today. I would like for them to stand and be recognized.

Dr. Carl Burgstiner and his wife, Dr. Burgstiner is President-elect of the Medical Society of Georgia. Dr. Burgstiner, will you and Mrs. Burgstiner stand, please!

Our other distinguished guest is Dr. Charles E. Davis, the President-elect of the Medical Society of Virginia. Mrs. Davis will join him tomorrow. Dr. Davis will you please stand and be recognized?

We welcome these guests from our sister states to our meeting.

It is now my pleasure and privilege to present our President for the past year, who has served you with such distinction, Dr. E. Harvey Estes, Jr.

#### MESSAGE OF THE PRESIDENT

PRESIDENT ESTES: Thank you, Fellow Members, Guests and Friends:

(Whereupon President Estes then presented his message of the President to the House of Delegates, as printed in the

*North Carolina Medical Journal*, Vol. 39, No. 5, May 1978.

At the conclusion of his presentation President Estes was accorded a standing ovation.)

SPEAKER LYMBERIS: Thank you, Dr. Estes, and I'm sure the warm applause represents the appreciation of this House of Delegates for your great efforts in their behalf during this past year. Your address will be referred to the Reference Committee on Presidential Addresses for further comment.

Always one of the outstanding features of this meeting is the report of the Medical Auxiliary. In the past year, this Auxiliary has been capably led by Mrs. Robert J. Andrews.

Mary Leila, I will ask your good husband to escort you to the platform. We would like to receive your report at this time.

[Whereupon Auxiliary President, Mrs. Robert Andrews, was escorted to the podium by her husband and accorded a standing ovation.]

#### MESSAGE OF THE PRESIDENT OF THE AUXILIARY

MRS. ROBERT (MARY LEILA) ANDREWS [President, Auxiliary of the North Carolina Medical Society]: Thank you, Mr. Speaker. Dr. Estes, Dr. Gardner, Officers and Members of the North Carolina Medical Society and My Fellow Auxiliaries and Guests: Mrs. Marian Gilliam from Gainesville, Florida:

In the fall of 1977, when the Auxiliary President appeared before the Executive Council of the North Carolina Medical Society at Mid Pines, I presented the Auxiliary projects for 1977-78 in the form of packages similar to the ones that are delivered by U.P.S. They would all be different shapes and sizes.

With 50 organized county auxiliaries and a membership, as of March 23rd, of 3,035 in the state; 2,929 in the national membership and 25 members-at-large, and a theme of "Total Health For The Total Family," I have kept my word and here are the packages!

Our first package is Membership! We're grateful to you for this privilege for our one criteria is that we are married to a physician. We all hope that those of you in the audience can boast that your spouse is among this number. If he or she is not, please encourage them to join us. We need them and they need us.

Our second package is AMA-ERF, American Medical Association Education and Research Foundation! This continues to be the only philanthropic endeavor sponsored by the AMA Auxiliary. We used to be in the selling business selling watches and rings to raise money for this fund, but now we stress memorials, honor gifts and the Sharing Christmas card.

The Sharing Christmas card is a beautiful card that is sent out by the Auxiliary and if you have made a contribution to



this with your spouse then only one card is sent to the physician in your town with a message saying, "My contribution . . ." — instead of sending individual Christmas cards and using the postage and buying the cards, that contribution will go to the AMA-ERF fund. Then the Auxiliary sends one card to each physician and family each year. This is an excellent way to make money.

I'm happy to report that on Saturday, our four medical schools will be receiving a check from the AMA-ERF to Bowman-Gray, over \$7,000; Duke, \$10,200; East Carolina, \$2,300; UNC School of Medicine \$8,100.

Representatives from those schools will receive the checks. Mrs. Paul O'Brian from Charlotte has served as our Chairman.

Our third box is marked, "Student Loan Fund"! This is a service project of the State Auxiliary. At the present time we have 71 loans out, totalling \$41,500 and currently, no loan is overdue.

In the last two years, two physicians have made their final payments and with their checks, gave a contribution expressing appreciation to the Auxiliary for its help in time of need.

Our fourth box is marked, "legislation and AMPAC-MEDPAC"! We have taken a very active role this year as in years past working with Mr. Stuart Shadbolt at the headquarters office, encouraging our members as you do yours, to join with us as we try to support candidates sympathetic to the cause of medicine.

Others who have been working diligently with the Auxiliary and within the Auxiliary are Dr. Archie Johnson, Dr. Edna Hoffman, Mrs. Lacy Stallings, Mrs. Archie Johnson, Mrs. Martha Martinat and many, many others.

One of our most important boxes that was delivered this year is "Community and Family Health." This includes reaching out into communities with programs such as "Safety on the Streets," "Clean Out the Medicine Cabinet and Storage Cabinet and Get the Poison Out of the Reach of Young Children."

You will find Auxiliary members also screening in grade school the eyes and the ears, working in bloodmobiles, cancer clinics, teaching CPR in the Heimlich maneuver and they will be bringing gifts to the patients in the mental hospitals; taking students and others through the four health museums that we have in the state: Charlotte, Greensboro, Asheville and now one in Wilmington.

Others will be painting pictures on the pediatric ward at the hospital, or purchasing the sleeping chairs so that a mother or father might have a more comfortable night sleep with a sick child.

One Auxiliary worked two years to raise money and plan a chapel for the hospital. This lovely room of worship with its beautiful stained glass windows was dedicated this past fall and named after a medical missionary, Dr. Lula Dussaway in New Bern. Still others of the Auxiliary are working with the foreign people and illiterates and teaching them to read.

Gastonia had a group monitoring TV programs to evaluate them for children and for adults to view and to make reports back to their Auxiliary and to the network.

Some auxiliaries are providing for women of the community programs of breast cancer, self-examination, surgery and rehabilitation, a seminar on depression or teenagers and parents.

Still others are providing programs for enrichment for medical marriages. And, one auxiliary even gave a retreat with their husbands. Were you a member of that group?

But, we must hurry on and see what else is in store in our black bag!

Our sixth box is "International Health" and we've had a

good time working in this area. We're deeply grateful to Mrs. Calvin MacKay for presenting at both regional workshops, at Wrightsville Beach and Greensboro, a film, "Gold From Bangladesh," featuring a Wilmington native, Dr. Herb. Codington, who is working with the Bengali physicians there in Bangladesh.

Dr. Codington asked that we raise money to send to the clinic for most of the women only have one sari which is their native dress.

By having "silver teas" this year, we have raised nearly \$800. In one of our auxiliaries, many Vietnam families have come in and as the women have adopted the western dress, they have given their own saris, so the Northampton-Halifax Auxiliary has mailed several packages of saris.

To keep our members informed, our seventh box is called, "Publications!" We have four excellent newspapers per year called, "*Tarheel Tandem*" capably edited by Sara Jo Blair and Ann Hubbard. We thank the Society for giving to us a page in the "*North Carolina Medical Journal*."

Your President has also tried to keep in touch with the counties through a monthly newsletter and, of course, we have our national magazine, "*Facets*," and many, many pamphlets on information from our national headquarters.

Our eighth box is "Research and Romance!" These are two projects sponsored by Southern Medical Association with much emphasis on history in 1976. Many of our counties have gone into many hours of work, researching and publishing books of the history of medical physicians and their practices in your counties. Many of them are coming out this year, so go back and you may be purchasing a book very soon.

Please let me interject here and remind you that Bea Troutman and Dr. Tom Dameron will be serving as President of Southern Medical Association and the Auxiliary to the Southern Medical Association at the same time.

The ninth box is labeled, "Fall Workshop, Mid-Winter Leadership Conferences and Communications Workshop with Burroughs-Wellcome and the North Carolina Medical Society!" A mighty small box, but a lot of information is in it.

This encompassed a wonderful weekend at Burroughs-Wellcome and we appreciate and are indebted to Dr. Estes, Dr. John McCain, Dave Reynolds of Burroughs-Wellcome and Dan Finch of our headquarters staff for including the Auxiliary in with this workshop.

I would be remiss if I did not mention three other boxes. I only have two with me.

"Health Manpower!" In here you will find our work with the highschool students in health career clubs, or with the elderly in nursing homes or volunteer services in the hospitals.

One health club member made a kit, a first-aid kit for their own use, but one young member had this kit down at the beach. A physician from Wilmington had the opportunity to use that kit on his own child because he didn't have his bag with him and we're grateful to these young people in their service.

And, then, one of the most important boxes is small but it's "Health Education!" Our immediate past president, Mrs. Edwin Martinat, deserves another rising vote of thanks as you gave her last year.

I believe you said, Mr. Speaker, she was the "hustler" and she has still been hustling for that health education bill. We hope that you will support this. May 31st, I believe, is the vote for the bill, House Bill 540.

Martha has kept two schedules this year and I have not found her at any time when I call on the phone when I need her help or advice.

Finally, let me say thank you for allowing your spouses to work with me in this wonderful organization. Thank you for eating a "Big Mac" at lunch while she attended a workshop.

Thank you for playing ball with the children or the grandchildren while we went to a leadership conference. Thank you for letting your spouse join with us as we try to do more together.

I left out our twelfth box which I do not have with me, but we cooperated with the AMA in the immunization program this year. We are very proud of North Carolina because very few of the counties needed the emphasis on these shots for our young children. It is required as our children enter first grade.

One Auxiliary went to the health department and they wouldn't take their word for it. They checked the records and the health department said, "We don't need your emphasis!" So, they said, "Let us check your records for five years and they did and then they went back to the Auxiliary meeting and wrote a letter of commendation because the health department was correct; they didn't need it.

To each of you, it has been a fun time, a fun year and if you will allow me one minute, I will tell you of a telephone conversation at ten minutes of eight to my neighbor down the street when I wanted somebody to ride with me to a meeting.

This is what her husband heard from the bathroom. They are from Holland and I can't speak that well:

"Yar, Mary Leila! Vat? Go to Washington and have lunch with ze Prezident? What day eez it? Tuesday? I can go! What time? Six o'clock, fine! Goodbye!"

Dr. Rolf Fisscher, a psychiatrist in Wilmington, came out of the bathroom and said, "Merika, where are you and Mary Leila going today?"

"Washington!"

"Washington?" "Are you driving or flying?"

"Driving!"

"And, you'll be back at six o'clock tonight?"

She said, "Yar!"

And, he said, "And have lunch with the President?"

She said, "Yar!"

He said, "D.C. or N.C.?" [Laughter]

By that time, Merika says she was so confused she didn't know whether she was going up to Little Washington or Washington, D.C.!

This is how much fun it has been in the Medical Auxiliary! Thank you.

[Whereupon the entire assemblage then again accorded Auxiliary President Andrews a standing ovation.]

SPEAKER LYMBERIS: Thank you, so much, Mary Leila. I will ask Dr. Henry Carr to assist your husband in escorting you back!

### HOUSE OF DELEGATES

Dr. Payne, will you present the report of the Credentials Committee?

DR. JOHN A. PAYNE, III [Chairman, Committee on Credentials]: Mr. Speaker, we have 174 delegates registered; 135 delegates are seated.

This 135 of the 174 represents a majority of the registered delegates and constitutes a quorum.

SPEAKER LYMBERIS: Thank you, Dr. Payne. We will now proceed with the business of the House.

I should like to remind those new delegates here that you are the controlling body of this Medical Society; you, the elected representatives of our component societies and special societies, are in charge of this Society.

You will vote on all issues that come before this House. You will elect the officers of your Society and our conduct is

governed by Constitution and Bylaws and by the parliamentary rules of Sturgis.

If this House is successful, the credit is yours; if it is a failure, the blame is yours. We have gone for many years with a very successful House and I'm certain that this House will be no exception to those that have preceded it.

We would like now to hear a report from Dr. John Dees or MEDPAC.

### REPORT OF N.C. MEDPAC

DR. JOHN T. DEES [Chairman, Board of Directors MEDPAC]: Mr. Speaker!, Mr. President, Members of the House of Delegates and Alternates, Ladies and Gentlemen and Friends:

I want to thank you for the opportunity to give a report to the House of Delegates on MEDPAC.

As most of you know, MEDPAC is the Medical Political Action Committee made up mainly of members of this Society and their spouses.

We have had a good year. Each year in MEDPAC seems to become a little more difficult. Fund raising has been good. Membership is at a good high. Without having any great issues like medical malpractice having faced us in the past year, we do have close to seven hundred members at the time of this meeting.

We want to continue to gain new members and in attempting to encourage membership, we did reduce the types of membership this year. We have just two types of membership. We have the regular membership at \$50, and sustaining membership of \$100.

We think and feel, the Board of Directors do, that every physician in North Carolina who's interested in the things that Dr. Estes talked about a few minutes ago, should more than welcome the chance to contribute \$100 towards better legislation affecting medicine.

During this year, we have concentrated, particularly in this last two or three months, more on our state legislature and candidates for the state legislature than in previous years because that's where so many of our battles seem to be won or lost.

We have accepted recommendations from physician members throughout the state about candidates to support and we have supported, I think without exception, every candidate running for office that a physician member in a society was strongly recommending.

If not, then, we can certainly justify that and would be glad to answer questions after the meeting — the members of the Board will.

We also have contributed on the national level to races for Congress and United States Senate and I think we have been very successful so far in those races. And, they continue on, as you know, in November.

I would like to particularly invite all of the members of the Society to our annual MEDPAC dinner which will be held in this room tomorrow night at seven-thirty. That's after most of the cocktail parties, or at least the official cocktail parties.

We will have a guest speaker, Mr. Paul Newman, not the actor but the political analyst and pollster who will talk on, I feel pretty sure, medical family participation in politics.

It will be short. We have an excellent menu. Mr. Newman's speech will not be too long. We will have a tribute to the late Dr. Ed. Beddingfield and we will be out in two hours. So, we do invite you to come tomorrow evening at seven-thirty.

Finally, I've been asked to remind you of the fact that Governor Hunt will be present here tomorrow morning.

So, we would ask you all to be here tomorrow morning at eight-thirty. I've got to go and get him at eight o'clock, so



you all ought to be here at eight-thirty! Thank you, very much.

### REPORT OF THE SPEAKER

SPEAKER LYMBERIS: Thank you, Dr. Dees.

The next item on the agenda is the 1978 Report of the Speaker of the House of Delegates. You have before you in your packet a summary of the actions that were taken at the last House of Delegates. I shall not waste your time by rereading these, but I will pause for a moment and ask if there are any questions concerning these actions which were taken at the last session of the House of Delegates.

Interim disposition of the actions of the 1977 House of Delegates.

1. REPORT A — Establishment of a Section on Nuclear Medicine.

Implemented by establishment of a new specialty section.

2. REPORT B — The Annual Budget Estimates for 1977. Operated within the Annual Budget, as approved. See Auditor's Report of 1977 operations contained in the Compilation of Annual Reports in the Delegate Kits.

3. REPORT C and SUPPLEMENTAL REPORT C — Proposed Changes in the Constitution and Bylaws.

Implemented, by revision of the Constitution and Bylaws as authorized. Second reading of the revised Constitution and Bylaws to be considered at the 1978 meeting of the House of Delegates.

4. REPORT D — Statement of Policy Concerning Medical Cost Containment.

Implementation in process, and filed as Society policy. Educational pamphlet for public consumption about twelve suggested ways in which patients may help reduce their medical costs.

5. REPORT E — Reaffirmation of Position Opposing Unskilled Non-Professional Midwifery and Home Deliveries.

Filed as Society policy, and still under further consideration through efforts to develop practical method of repeal of the related regulatory statute as means of implementation of intent of the Report.

6. REPORT F — Establishment of Policy that All Public Programs of Mental Health in North Carolina should Develop and Maintain High Professional Standards.

Filed as Society policy.

7. REPORT G — Change Name of Committee on Public Relations to Committee on Communications and Expanded Public Relations Program.

Implemented change of Committee name. Expanded Public Relations Program being implemented in stages.

8. REPORT H — Increase in Annual Dues.

Implemented. The 1978 dues invoices submitted and collected at the increased approved amount.

9. REPORT I — Nomination of Maurice A. Kamp, M.D., for Election to Honorary Membership.

Implemented by presentation of Life Membership to Dr. Kamp.

10. REPORT J — Memorial Resolution to J. Street Brewer, M.D.

Implemented by distribution of the Memorial Resolution as directed.

11. REPORT K — Transfer of Davie County from Rowan-Davie County Medical Society to Forsyth County Medical Society.

Implemented and Bylaw change affected.

12. REPORT L — Establishment of a Section on Plastic and Reconstructive Surgery.

Implemented by establishment of a new specialty section.

13. REPORT M — Policy Statement Relating to Proposed Physician Assistant Programs.

Filed as Society policy.

14. RESOLUTION No. 1 — Advertising by Physicians. Filed as Society policy.

15. RESOLUTION No. 3 — Medical Examiner Fees and Pathology Fees for Medical Examiner Cases.

Referred to the Committee on Legislation and to the North Carolina Department of Human Resources.

16. RESOLUTION No. 4 — Establish a Mechanism to Advise, Assist and Support the Members of the North Carolina Medical Society in Counter Suits.

Implemented by referral to the Committee on Professional Insurance of any requests from members for assistance.

17. RESOLUTION No. 5 — Establish a Mechanism to Assist New Physicians in Locating in Areas Where There is Great Health Care Need.

Implemented by incorporation in the operating practices of the Society's Physician Placement Service.

18. RESOLUTION No. 6 — Appreciation of Mr. William N. Hilliard

Implemented by referral of a copy of the Resolution to the concerned party.

19. RESOLUTION No. 7 — Delaney Amendment to Food, Drug & Cosmetic Act of 1958.

Filed as Society policy and by referral of the information to the appropriate parties.

20. RESOLUTION No. 8 — Proposed Bill for the General Assembly of North Carolina entitled "An Act to Redefine the Practice of Optometry Consistent with Modern Advances in the Science of Optometric Medicine."

Referred to the Committee on Legislation and filed as Society policy.

21. RESOLUTION No. 10 — Encourage Further Development and Use of Home Health Programs and Services.

Filed as Society policy.

22. RESOLUTION No. 11 — Opposition to Use of Laetrile.

Filed as Society policy.

23. RESOLUTION No. 12 — Post Inspection survey Critiques.

Filed as Society policy.

24. RESOLUTION No. 13 — Opposition to H.R. 2222. Resolution introduced into AMA House of Delegates by North Carolina Delegation, and filed as Society policy.

### NOMINATION AND ELECTION OF OFFICERS

We will proceed to the report of the Committee on Nominations. Only the Committee on Nominations knows what this contains and it is the privilege of the President to open this envelope and let you know who has been nominated for your future leadership. Dr. Estes!

PRESIDENT ESTES: In accordance with our bylaws, the Chairman of the Committee on Nominations, Dr. Leon Robertson, forwarded to me by registered mail several weeks ago a sealed envelope containing the recommendations of the committee for the officers of the Society for the next year.

Before I open this sealed envelope and read the names, I would like to say a few words in tribute to Dr. Oscar Sapp of Chapel Hill, whose death occurred during this past year.

As most of you know, Oscar served as the Chairman of the Committee on Nominations for two years and was Chairman at the time of his death. We all remember Oscar as a quiet, sincere person who was willing to share more than his load, who always did more than you expected of him, and who did it well. He served the Society in a number of important ways

and over a period of many, many years and he was a friend of scores of us in this room and he will be sorely missed.

Mr. Speaker, I will open the envelope and read the recommendations of the Committee on Nominations and as a voting member of this House of Delegates, I will place these names in nomination for their respective offices.

The North Carolina Medical Society nominees for 1978-79:

For President-elect, Dr. Joseph Benjamin Warren, New Bern;

For First Vice President, Dr. Archie T. Johnson, Jr., Raleigh;

For Second Vice President, Dr. Albert Stewart, Jr., Fayetteville;

For Speaker, Dr. Marvin N. Lymberis, Charlotte;

For Vice Speaker, Dr. Henry J. Carr, Jr., Clinton.

**SPEAKER LYMBERIS:** You have heard the nominations. Are there any nominations from the floor for these offices?

Hearing none, do I hear a motion that the slate be elected by acclamation? [Whereupon the motion was severally made from the floor.]

Is there a second? [Whereupon the motion was severally seconded from the floor.]

I hereby declare the slate elected by acclamation, Mr. President.

Dr. Warren, where are you seated? Ben, will you come forward and let us have a good look at you? [Whereupon the entire assemblage then accorded Dr. Warren a standing ovation as he proceeded to the podium.]

**DR. J. BENJAMIN WARREN:** My mouth is still dry and my heart is beating a little fast!

I thank you. I don't know how I was chosen for this. I'm not as efficient as Harvey Estes, although we both went to Duke! [Laughter] Or, have been associated with Duke. I'm not as pretty as Charlie Styron, although we both went to New Bern! And, I'm not as smart as — I'll have to think about that for a little while! [Laughter]

But, I thank you. I'll try to do a good job, as good a job as my predecessors. Thank you. [Applause]

**SPEAKER LYMBERIS:** Thank you, Ben, and I know that you will have the support of this House of Delegates.

Other nominations which you have received by mail previously for other offices will be reread to you by Dr. Leon Robertson, Chairman, Committee on Nominations. Dr. Robertson!

**DR. LEON W. ROBERTSON** [Chairman, Committee on Nominations]: Mr. Speaker, and Members of the House: This is not a secret thing. You've had these for several weeks now, but I will read to you and place their names in nomination as a voting member of the House, the names:

Councilors for a three year term:

Fifth District, Dr. Bruce B. Blackmon, Buies Creek;

Seventh District, Dr. J. Dewey Dorsett, Jr., Charlotte;

Tenth District, Dr. Charles T. McCullough, Asheville.

For Vice Councilors for a three year term:

Fifth District, Dr. Giles L. Cloninger, Jr., Hamlet;

Seventh District, Dr. James B. Greenwood, Jr., Charlotte;

Tenth District, Dr. W. Otis Duck, Mars Hill.

For the North Carolina Board of Medical Examiners for a six year term:

Dr. A. T. Pagter, Tryon;

Dr. Louis T. Kemon, Raleigh.

For AMA Delegates from January 1, 1979 to December 31, 1980:

Dr. John Glasson, Durham;

Dr. James E. Davis, Durham;

Dr. Frank R. Reynolds, Wilmington.

From January 1, 1978 to December 31, 1979 to fill the unexpired term of the late Dr. Edgar T. Beddingfield, Jr., we nominate:

Dr. Louis deS. Shaffner, Winston-Salem.

For AMA Alternate Delegates from January 1, 1979 to December 31, 1980:

Dr. Jesse Caldwell, Jr., Gastonia;

Dr. E. Harvey Estes, Jr., Durham;

Dr. M. Frank Sohmer, Jr., Winston-Salem.

There are no vacancies in the North Carolina Division of Health Services.

For the North Carolina Medical Care Commission for a four year term:

Dr. Hugh F. McManus, Jr., Raleigh.

For the Editorial Board of the "North Carolina Medical Journal," for a four year term:

Dr. Robert W. Prichard, Winston-Salem,

Dr. George Johnson, Chapel Hill,

Dr. Edwin W. Monroe, Greenville.

For the Board of Trustees of Blue Cross & Blue Shield of North Carolina, Inc. for a three year term:

Dr. H. Fleming Fuller, Kinston;

Dr. Frederick A. Blount, Winston-Salem.

**SPEAKER LYMBERIS:** Thank you, Dr. Robertson. You have heard the nominations. Are there any other nominations from the floor?

Hearing none, do I hear a motion that they be elected by acclamation? [Whereupon the motion was severally made from the floor.]

Is there a second? [Whereupon the motion was severally seconded from the floor.]

They're so elected. Thank you.

## CONSTITUTION AND BYLAWS

I will now ask Dr. Henry Carr, our very competent and capable Vice Speaker to present the report of the Committee on Constitution and Bylaws in place of the Chairman, Dr. Louis Shaffner.

Dr. Carr has not only served as Vice Speaker, but he has been a member of this Committee on Constitution and Bylaws and is certainly most capable in presenting this report to you.

**DR. HENRY J. CARR** (Member, Committee on Constitution and Bylaws.) Thank you, Mr. Speaker. First, I would like to commend Dr. Louis Shaffner for the excellent work he has done, as chairman, in guiding the Committee on Constitution and Bylaws in the difficult and monumental task of revising the Constitution and Bylaws of our Society.

As a member of the Committee on Constitution and Bylaws, I would like to submit the following report for further action by the House of Delegates.

## REPORT C and SUPPLEMENTARY REPORT C

A. A first draft of the revised Constitution and Bylaws was presented to the House of Delegates in 1977. Some amendments to it were adopted by the House at that time. Since then, other amendments have been suggested and are recommended by the Committee on Constitution and Bylaws and have been approved by the Executive Council.

These are the several following items:

*Item 1:* Delete Section 3 of Chapter IV, page 4, of your new proposed revision. This section required that a paper to be considered for an award must be submitted in writing. Since the Committee on Awards is proposed to be deleted, this section may no longer be appropriate.



*Item 2:* Amend Section 5(d) regarding the Editorial Board, of Chapter V on page 6 by changing the first word "seven" to "Eight" so that the sentence will read: "Eight elective members of the Editorial Board of the 'North Carolina Medical Journal' shall be elected by the House of Delegates to serve terms of four years." This amendment will allow the Editorial Board to consist of one faculty member from each of the four medical schools and four at large members.

*Item 3:* Amend Section 2 regarding Eligibility for Election, of Chapter VI on page 7, by adding as the next to the last sentence of the section the following: "A member serving out the unexpired term of office of another member shall be eligible for re-election to that office."

*Item 4:* Amend Chapter IX on page 9 by deleting the name "Committee on Awards" from Section 3, by deleting the description of the Committee on Awards as Section 5, and by renumbering the remaining Committees and Sections in numerical order.

The Committee on Awards met during the year. They assessed their function in view of the current format of the annual meetings as they are now held and they recommended that the committee be dissolved. The Council on Review and Development and the Executive Council have approved that recommendation.

*Item 5:* Amend Chapter V, Section 1, by changing one sentence in the body of the section to read as follows:

Each such component medical society shall be entitled to one delegate for its first twenty-five voting members or fewer and one additional delegate for each additional twenty-five voting members or major fraction thereof, provided that in any event there shall be at least one delegate from each county, as specified in Chapter XI, Section 2.

B. The accompanying 1978 draft of the Constitution and Bylaws that you have in your packet, has been revised from the 1977 draft to incorporate the amendments adopted by the House in 1977 and also the amendments listed in one through five outlined above. Items one through five require action by the House and other amendments may be made.

When action on all these amendments has been taken, the document is ready for adoption. This requires one motion to adopt and only majority vote is needed to pass.

Upon adoption, the new Constitution and Bylaws goes into effect.

C. The Committee on Constitution and Bylaws recommends that after the adoption, the House authorize the publication of the adopted version of the document in the "North Carolina Medical Journal" and that additional copies be made available as needed to the membership.

Mr. Speaker this completes the report of the Committee on Constitution and Bylaws.

(Adopted. See pages 63 & 64.)

SPEAKER LYMBERIS: Thank you, Dr. Carr. This report will be submitted to Reference Committee III. If you have any questions, any disagreements, you have an op-

portunity to present yourselves to Reference Committee III tomorrow afternoon and state your case and this Reference Committee will be glad to hear you.

### ANNUAL REPORTS

In your packet, you have a Compilation of Annual Reports. I'm sure you don't want me to read all these out loud here today. So, do I hear a motion that these Annual Reports be accepted?

(The motion was duly made and seconded from the floor.)

All those in favor say "aye"; all opposed "no." The motion is carried.

I would like now to turn the Chair over to Vice Speaker Carr.

VICE SPEAKER CARR: At this time, I will call on President Harvey Estes who will report on recent Executive Council activities.

### EXECUTIVE COUNCIL SUMMARIES AND REPORTS OF THE EXECUTIVE COUNCIL

PRESIDENT ESTES: Mr. Vice Speaker and Members: Each of you have received in your packets, the summaries of the actions of the Executive Council at its sessions on September 25, 1977, February 5, 1978 and April 16, 1978. (See pages 40-45.)

These summaries include actions by the Executive Council which it felt did not require special reports, but which are submitted in summary for your consideration and hopefully your approval.

I, therefore, move approval of the actions by the Executive Council enumerated in these summaries of the Executive Council meetings. I so move.

VICE SPEAKER CARR: Do I hear a second to his motion? [Whereupon the motion was seconded from the floor.] Is there any discussion on Dr. Estes' motion?

All those in favor say "aye"; all opposed "no." The motion carries.

PRESIDENT ESTES: You also have received in your delegate packet, reports "A" through "G" which originated from actions of the Executive Council at those same three meetings. I, therefore, move that these lettered reports as printed, except for those reports already presented by the Committee on Constitution and Bylaws, be received at this time for consideration by the House of Delegates and referred to the Reference Committees as indicated, without being read or further identified. I so move, Mr. Vice Speaker.

VICE SPEAKER CARR: Do I hear a second to his motion?

DR. A. J. CRUTCHFIELD [Forsyth County]: Second.

VICE SPEAKER CARR: Is there any discussion of the motion? (No response) All those in favor say "aye"; opposed "no." The motion carries.

## REPORT A

SUBJECT: The Annual Budget Estimates for 1978

REFERRED TO: Reference Committee No. 1

The Executive Council, at its September 25, 1977, meeting, considered the proposed budget estimates for 1978 recommended by the Committee on Finance.

The Budget Estimates for 1978 were adopted by the Council. The Budget Estimates for 1978 are as follows:

**BUDGET ESTIMATES**  
January 1, 1978 to December 31, 1978

## REVENUES: (ESTIMATED)

	1977	1978
Estimated balance January 1, 1978 .....	\$ 60,000	\$ 15,000
Annual Dues, paying members .....	480,000	650,000
Sales—Rosters & Journals .....	6,500	6,500
Revenue Unexpected .....	1,000	800
Technical Exhibits .....	10,500	11,600
Journal Advertisement—Local .....	10,500	11,000
Journal Advertisement—National .....	20,500	17,000
**AMA Remittance 1% of dues processed .....	8,000	8,000
MEDPAC Remittance 1% of dues processed .....	300	300
Rental Income—Headquarters Facility .....	55,000	42,600
Rental Income—Residential Property .....	3,000	3,000
Interest Income—Operating Funds .....	9,500	16,000
Interest Income—Notes Receivable—Sale of Property .....	—0—	6,200
Interest Income on Reserve Fund .....	18,000	20,000
Reimbursement for Headquarters Office Services .....	6,000	6,000
	<u>\$688,800</u>	<u>\$814,100</u>

\*\*To be appropriated to Secretarial Budget A-6

## EXPENDITURES: (ESTIMATED)

	1977	1978
Schedule A .....	\$353,493	\$400,210
Schedule B .....	91,600	100,020
Schedule C .....	36,553	40,400
Schedule D .....	27,000	29,250
Schedule E .....	9,960	27,900
Schedule F .....	26,600	30,120
Schedule G .....	55,194	50,990
Schedule M .....	70,400	79,000
Schedule R .....	18,000	56,200
	<u>\$688,800</u>	<u>\$814,100</u>

EXCESS OF RECEIPTS OVER EXPENDITURES .....	—0—	—0—
EXCESS OF EXPENDITURES OVER RECEIPTS .....	—0—	—0—
RESERVES: (Estimated Cash Reserves—\$306,277)		

SUBMITTED TO COMMITTEE ON FINANCE .....	September 11, 1977
SUBMITTED TO EXECUTIVE COUNCIL FOR APPROVAL .....	September 25, 1977
SUBMITTED TO HOUSE OF DELEGATES FOR APPROVAL .....	May 4, 1978

## A. EXECUTIVE BUDGET

A- 1 President, expense of (travel communications)* .....	\$ 8,500	\$ 8,500
A- 2 President's secretarial assistance .....	5,000	5,000
A- 3 Secretary, travel of* .....	1,000	1,000
A- 4 Executive Director-Treasurer, salary of .....	39,200	44,000
A- 5 Executive Director-Treasurer, travel of .....	6,500	7,000
A- 6 Executive Office, Secretarial & Clerical Assts.** .....	73,000	83,000
A- 7 Executive Office, equipment-replacements .....	4,000	4,000
(a) Reserve for future equipment-replacements .....	2,000	2,000
A- 8 Executive Office, expense of (communications, printing, and supplies, repairs and replacements of expendables) .....	30,000	32,000
A- 9 Bonding .....	255	28
A-10 Audit (Quarterly and Annual) .....	3,200	3,200
A-11 Taxes (Salary tax) .....	11,000	13,250
A-12 Insurance: fire, liability & compensation .....	2,300	2,500



A-13	Membership records & acctg. forms, IBM Machine Service .....	12,000	4,500
A-14	Publications, reports & executive aids .....	350	375
A-17	Assistant to Executive Director & Convention Coordinator, salary of .....	21,638	24,230
A-18	Field Representative, salary of (MC) .....	12,600	14,490
A-19	Field Representative, salary of (DF) .....	11,000	13,200
A-20	Director Field Services, travel of* (GS) .....	3,000	3,000
A-21	Director Governmental Affairs, travel of* (SWS) .....	2,000	2,000
A-22	Controller, salary of .....	23,945	26,815
A-23	Director Field Services, salary of (GS) .....	20,917	23,425
A-24	Director Governmental Affairs, salary of (SWS) .....	18,753	19,000
A-25	Field Representatives, travel of* .....	5,000	5,000
A-30	Retirement System for Society .....	31,500	37,000
A-31	NCMS Headquarters Staff Hospitalization .....	4,835	5,200
A-32	Principal Payment on System/32 .....	—0—	7,828
A-33	Interest Payment on System/32 .....	—0—	2,412
A-34	NCMS Administrative Staff Disability Insurance .....	—0—	6,000
		<u>\$353,493</u>	<u>\$400,210</u>

Basis: Real for personal maintenance and travel @17¢ per mile and/or carrier rate and for official purposes.

\*Any revenue derived from collection efforts related to American Medical Association dues and processing of same shall accrue to this item of the Budget.

### B. JOURNAL BUDGET

B-1	Journal, printing and mailing .....	\$ 65,000	\$ 72,300
B-5	Editorial office, expense of (12 months rent, communications, printing, and supplies, repairs and replacements) .....	550	575
B-6	Journal Business Manager's office, expense of (12 months communications, printing, and supplies, repairs and replacements) .....	925	900
B-7	Business Manager's Office, equipment for .....	100	100
B-8	Journal, travel for (local and national) .....	100	250
B-9	Taxes (Salary tax) .....	1,225	1,400
B-10	Sales tax on Journal Subscriptions and Roster Sales .....	2,500	2,700
B-11	Journal Salaries (Editor, Advertising Secretary, Editor's Secretarial Assistance) .....	21,200	21,800
		<u>\$ 91,600</u>	<u>\$100,025</u>

### C. INTRA-FUNCTIONAL ACTIVITY BUDGET

C-1	Executive Council expense of and travel of Councilors including district travel .....	5,300	6,000
C-2	Publication of Executive Council Minutes, Transactions, Annual Reports .....	6,000	6,000
C-3	Committee on Legislation, expense of (Local and National activity) .....	6,500	9,500
C-4	Maternal Health Committee, expense of (secretarial, communications, printing and supplies) .....	300	300
C-5	Committee on Drug Abuse .....	C-11	C-11
C-6	Committee on Arrangements .....	C-11	C-11
C-7	Committee on Exhibits, expense of (including \$1,000 for Scientific Exhibit Awards) ....	1,980	1,700
C-8	Committee on Mental Health .....	C-11	C-11
C-9	Mediation Committee .....	3,000	3,000
C-10	Committee on Chronic Illness, TB, & Heart Disease .....	C-11	C-11
C-11	Committees in general, expense of (including committees under \$100 allocations) .....	5,000	6,000
C-12	Committee on Nominations .....	C-11	C-11
C-13	Committee on Occupational & Environmental Health .....	500	C-11
C-14	Committee on Professional Insurance .....	C-11	C-11
C-17	Committee Advisory to Medical Students (Section) (Expense of Delegates to AMSA & AMA Annual Meetings — one each Medical School Chapter) .....	2,875	2,500
C-18	Committee on Disaster & Emergency Medical Care .....	C-11	C-11
C-19	Committee to Work with Industrial Commission .....	C-11	C-11
C-20	Committee on Constitution & Bylaws .....	1,500	1,500
C-21	Medical-Legal Committee .....	C-11	C-11
C-22	Committee on Traffic Safety .....	C-11	C-11
C-23	Committee on Cancer .....	C-11	C-11
C-24	Committee on Anesthesia Study .....	398	400
C-25	Committee on Child Health & Infectious Disease .....	C-11	C-11
C-26	Committee on Blue Shield .....	C-11	C-11
C-27	Committee on Hospital & Professional Relations & Liaison to N.C. Hospital Association ..	C-11	C-11
C-28	Committee on Social Services Program (Including Medicaid) .....	C-11	C-11
C-30	Insurance Industry Committee .....	C-11	C-11

C-31	Committee on Community Medical Care, sponsorship of 4-H Health activity for one trip to National 4-H Club for State Health Winner, and Today's Health subscription to 4-H Health Winners; miscellaneous expense .....	800	80
C-32	Retirement Savings Plan Committee .....	C-11	C-1
C-34	Committee on Medical Cost Containment .....	C-11	C-1
C-36	Committee on Marriage Counseling & Family Life Education .....	C-11	20
C-37	Committee on Medicine and Religion .....	200	dissolve
C-38	Committee Advisory to Auxiliary (Chairmanship includes Auxiliary under item D-3) ....	C-11	C-1
C-39	Committee on Credentials .....	C-11	C-1
C-40	Committee on Scientific Awards .....	C-11	C-1
C-41	Committee on Rehabilitation Medicine .....	C-11	C-1
C-42	Committee on Eye Care and Eye Bank .....	C-11	C-1
C-45	Council on Review and Development .....	C-11	C-1
C-46	Committee on Finance .....	C-11	C-1
C-49	Committee on Medical Education .....	500	50
C-51	Committee on Medical Aspects of Sports .....	1,000	1,00
C-53	Committee on Allied Health Professionals .....	C-11	C-1
C-54	Committee Liaison to N.C. Pharmaceutical Association .....	C-11	C-1
C-55	Committee on Personnel & Headquarters Operations .....	C-11	C-1
C-57	Advisory Committee to Crippled Children's Program .....	C-11	C-1
C-61	Committee on Audio-Visual Programs .....	200	25
C-62	Committee on Health Planning & Development .....	500	75
		<u>\$ 36,553</u>	<u>\$ 40,40</u>

#### D. EXTRA-FUNCTIONAL ACTIVITY BUDGET

D- 1	Delegates and Alternates to AMA Annual and Clinical Sessions .....	\$ 18,350	\$ 20,50
D- 2	Conference Dues .....	250	35
D- 3	Woman's Auxiliary (contribution to State Convention, travel for 2 to National Auxiliary, printing & secretarial needs, and State President's Discretionary Fund) .....	5,400	5,40
D- 5	President's Communication Program .....	3,000	3,00
		<u>\$ 27,000</u>	<u>\$ 29,25</u>

#### E. COMMUNICATIONS BUDGET (Formerly — Public Relations Budget)

E- 3	Committee Chairman, out-of-state travel .....	\$ 500	\$ 50
E- 9	Audio-Visual depiction, photography, radio-motion pictures, production, distribution and printing, purchase of films, etc. ....	100	10
E-10	Educational distribution, reprints, periodicals, press materials, pamphlets, and dodgers for educational purposes, production, distribution and printing, binding, stuffing and mailing .....	300	30
E-11	News and press releases, production and printing of .....	300	80
E-12	The Bulletin, production and printing of .....	5,500	5,50
E-13	N.C. Academy of Science/High School Student Program .....	160	20
E-14	Exhibits and Displays: Purchase, rental production, fabrication & transportation of .....	—0—	—0—
E-15	Conference for Medical Leadership .....	1,600	1,60
E-17	American Medical News subscriptions .....	300	—0—
E-18	Collateral Public Relations with other committees .....	1,000	50
E-19	N.C. Rescue Squad First Aid Trophies .....	200	20
E-20	"Health Watch" Weekly Health News Articles .....	—0—	1,50
E-21	Radio Program .....	—0—	5,20
E-22	County Medical Society Press-Medical Dinners .....	—0—	3,50
E-23	TV Public Service Announcements .....	—0—	6,00
E-24	County Secretaries and Executive Secretaries Clinics .....	—0—	1,00
E-25	Press Party .....	—0—	1,00
		<u>\$ 9,960</u>	<u>\$ 27,90</u>

#### F. ANNUAL SESSIONS (124th) CONVENTION BUDGET

F- 1	Program, production of .....	\$ 3,300	\$ 3,600
F- 2	Hotel and Auditorium expense .....	6,800	8,500
F- 3	Publicity promotion, expense of (reporters and expense) .....	200	100
F- 4	Entertainment (general involving personnel) .....	1,400	1,500
F- 5	Orchestra and Floor entertainment .....	1,500	1,500
F- 6	Guest Speakers expense and/or honorarium .....	2,500	3,600



F- 8	Electric Amplification, operators, installations and screening auditorium .....	—0—	—0—
F- 9	Booth installations, supplies, expense signs (scientific and technical), including exhibit expense & promotion .....	5,000	5,300
F-10	Projection, expense of (service rentals) .....	800	800
F-11	Badges (members, guests, exhibitors, auxiliary) .....	300	300
F-12	Reporting Service for Transactions—(House of Delegates, General Sessions and Reference Committees) .....	3,000	2,500
F-13	Rental, extra facilities, trucks for sections and/or exhibits .....	200	225
F-14	Exhibitors entertainment .....	1,000	1,425
F-15	Floral expense .....	300	475
F-16	Police Security .....	300	300
		<u>\$ 26,600</u>	<u>\$ 30,125</u>

#### G. MISCELLANEOUS BUDGET

G- 1	Legal Counsel, retainer fees for .....	\$ 26,000	\$ 35,000
G- 2	Reporting, Executive Council Meetings .....	2,500	2,500
G- 3	Fifty Year Club Pins and Certificates and President's Jewel .....	600	600
G- 4	Contingency and Emergency .....	13,594	490
G- 6	Advolorem Taxes (Personal Property) .....	3,100	2,900
G- 7	Association of Professions .....	200	200
G-10	Commissioners, expense of .....	1,500	1,500
G-11	Executive Committee, expense of .....	300	300
G-12	Officers, expense of .....	2,000	2,000
G-13	Travel and Maintenance, expense of essential headquarters staff for out-of-state meetings and in-state conferences .....	2,500	2,600
G-15	Other Property Taxes and Insurance (Fonville Property and Partin Property) .....	700	700
G-16	Residential Property Repairs (Fonville Property and Partin Property) .....	1,200	1,200
G-17	Contribution to MEDPAC Educational Fund .....	1,000	1,000
		<u>\$ 55,194</u>	<u>\$ 50,990</u>

#### M. HEADQUARTERS FACILITY BUDGET

##### *Operating Costs*

M- 5	Utilities .....	\$ 25,000	\$ 32,000
M- 6	Insurance .....	1,800	1,900
M- 7	Taxes (Real Property) .....	16,500	16,500
M- 8	Water .....	800	800
M- 9	Janitorial Services .....	14,000	14,000
M-10	Grounds Maintenance .....	1,800	1,800
M-11	Building Repairs & Maintenance .....	4,500	4,500
M-12	Heating, A/C Repairs & Maintenance, Elevator Maintenance .....	6,000	7,500
		<u>\$ 70,400</u>	<u>\$ 79,000</u>

#### R. OPERATING BUDGET RESERVES

R- 1	Interest on Notes Receivable sale of property .....	\$ —0—	\$ 6,204
R- 2	Interest on Reserve Fund .....	18,000	20,000
R- 3	New member Dues for Reserve Fund .....	—0—	30,000
R- 4	5% of Operating Budget .....	—0—	—0—
		<u>\$ 18,000</u>	<u>\$ 56,204</u>

(Adopted. See page 64.)

#### REPORT B

SUBJECT: Level of Medicaid Payments

REFERRED TO: Reference Committee No. 11

The September 25, 1977, meeting of the Executive Council considered a resolution from the Committee on Social Services Programs with regard to the level of Medicaid payments. After considerable discussion and amendment by the Executive Council of the resolved portion, the resolution was approved as amended, as follows:

WHEREAS, the North Carolina Medical Society

supports the goal of excellent medical care for all patients, and

WHEREAS, many physicians are discouraged from seeing Medicaid patients because of the low rate of reimbursement, and

WHEREAS, federal guidelines allow a fee of 100 per cent of the 75th percentile, therefore, be it

RESOLVED, that the North Carolina Medical Society supports payment of 100% of the level allowable by the Department of Health, Education, and Welfare

based on the previous twelve months data.  
(Adopted. See page 68.)

### REPORT C

SUBJECT: Amendments to Bylaws and Presentation of Final Draft of Revised Constitution and Bylaws for adoption  
REFERRED TO: Reference Committee No. III

(See pages 50 and 51, Report of the Committee on Constitution and Bylaws.)

(Adopted. See page 63.)

### SUPPLEMENTARY REPORT C

SUBJECT: Amendments to Bylaws

REFERRED TO: Reference Committee No. III

(See pages 50 and 51, Report of the Committee on Constitution and Bylaws.)

(Adopted. See page 63.)

### REPORT D

SUBJECT: Opposition to HEW Elimination of Payments for Abortions to the Poor and Indigent, and to ask the Legislature to make Funds available for Abortions to the Poor and Indigent

REFERRED TO: Reference Committee No. II

At the September 25, 1977, meeting of the Executive Council, the Committee on Maternal Health recommended, and the Executive Council approved that the North Carolina Medical Society go on record opposing the Department of Health, Education, and Welfare elimination of payments for abortions to the poor and indigent. That the Medical Society actively seek to influence the Legislature of North Carolina to make funds available for abortions to the poor and indigent.

The Committee reported that in the maternal mortality report given there was indication there has not been a maternal death since 1972 due to infection related to criminal abortion. The overall maternal mortality has declined, perinatal mortality has likewise declined in a similar period of time.

Based on these observations, the Committee on Maternal Health proposes the following resolution to the Executive Council of the North Carolina Medical Society:

WHEREAS, the fertility rate in North Carolina remained constant since 1972, while birth rates have dropped and elective abortions have increased,

WHEREAS, fetal mortality rates and maternal mortality rates have significantly declined during the same period of time, it is reasonable to postulate that free access to abortion has improved maternal health by systematically eliminating a significant number of unwanted pregnancies and pregnancies which otherwise would have prejudiced the mothers in North Carolina.

WHEREAS, recent legislation abolishing Title XIX and Title XX payment for abortions for the indigent woman it is certain that medical abortions will not be available for the poor and that they will resort to criminal abortions as in times preceding the legislation legalizing abortions in 1973 and that maternal mortality will increase infection resulting from criminal abortion and that more unwanted and thereby uncared for children will be born to a life of abuse and poverty.

Be it, therefore, RESOLVED, that the Committee on Maternal Health recommend to the Executive Council that the North Carolina Medical Society go on record opposing the Department of Health, Education and Welfare elimination of payments for abortions of

the poor and indigent. That the Medical Society actively seek to influence the Legislature of North Carolina to make funds available for abortions to the poor and indigent.

(Adopted. See page 68.)

### REPORT E

SUBJECT: Policy Statement Supporting the Use of Approved Automobile Child Restraints for Children Aged One to Five

REFERRED TO: Reference Committee No. I

The February 5, 1978, meeting of the Executive Council considered and approved a recommendation from the Committee on Traffic Safety to the effect that:

"The Committee on Traffic Safety recommends to the Executive Council that the North Carolina Medical Society go on record supporting the use of approved automobile child restraints for children aged one to five."

(Adopted. See page 64.)

### REPORT F

SUBJECT: Increase in Fee Permitted to be Charged by the Board of Medical Examiners for the Issuance of a License  
REFERRED TO: Reference Committee No. II

The April 16, 1978, meeting of the Executive Council received a request from the Secretary of the Board of Medical Examiners that the Executive Council present to the House of Delegates the following report:

Because of the increasing cost of Examination and Licensure by the Board of Medical Examiners, the Board of Medical Examiners request that the fee for Licensure by Endorsement remain at \$100 and the fee for Examination and Licensure shall be \$200.

By way of explanation, it was explained that the cost of obtaining the FLEX written examination from the Federation of Licensing Boards has recently increased sharply and the Board requests the support of the Society for a legislative change which would permit the Board to charge the needed higher fee.

In keeping with their request, the Executive Council adopted the following resolution:

BE IT RESOLVED THAT, the North Carolina Medical Society recommends that the General Statutes of North Carolina be amended to authorize the Board of Medical Examiners to charge a fee not to exceed \$200 for the issuance of a license to practice medicine by examination as provided in G.S. 90-15.

(Adopted. See page 68.)

### REPORT G

SUBJECT: Recommendations for Implementation of a Voluntary Cost Containment Program in North Carolina  
REFERRED TO: Reference Committee No. I

The April 16, 1978, meeting of the Executive Council considered recommendations for implementation of a Voluntary Cost Containment Program in North Carolina as a joint project between the North Carolina Medical Society and the North Carolina Hospital Association.

Following discussion, the Council adopted a motion endorsing the concept of the recommendations for implementation, but included in the motion sentiment in favor of broadening the public representation in the implementation. Approval was also recommended for financial support up to \$7,500.

An abridgement of the recommendations presented to the Executive Council is as follows:



## RECOMMENDATIONS FOR IMPLEMENTATION OF A VOLUNTARY COST CONTAINMENT PROGRAM IN NORTH CAROLINA

—That the first step be the creation of a North Carolina Steering Committee to be appointed jointly by the President of the North Carolina Medical Society and the Chairman of the Board of Trustees of the North Carolina Hospital Association.

This Committee would be comprised of:

- 1) Two physicians appointed by the President of the Society.
- 2) Two hospital administrators appointed by the Chairman of the association.
3. Two hospital trustees appointed jointly by the two officers.
- 4) One representative from Blue Cross and Blue Shield.
- 5) One representative from the commercial insurance industry.
- 6) One representative from state government.
- 7) One representative from the North Carolina Citizens Association to represent the business community.
- 8) One representative from the North Carolina Association of County Commissioners to represent local governmental elected officials.
- 9) One representative from The Duke Endowment.

It was suggested that representatives from organizations other than health care providers be jointly selected by the President of the Society and the Chairman of the Association from two names submitted by each of the stipulated organizations.

—That this Steering Committee would have an initial meeting to review all of the guidelines and objectives of the National Program and to adopt those applicable for immediate implementation in North Carolina. The Steering Committee would report to the governing boards of both the Society and the Association on its activities at regular periodic intervals.

—That the Committee call upon the Governor of North Carolina to apprise him as the Chief Elected Officer of the State of the Committee's goals and seek whatever cooperation and assistance he might offer.

—That the establishment of the program be widely communicated through the news media and other sources to all North Carolinians.

—That the North Carolina Hospital Association retain or appoint a staff member who shall act as director and coordinator of the program and to serve as staff to the Committee. This person would call upon such technical expertise as needed from the Medical Society, insurance industry, government, The Duke Endowment, or other sectors as required to effect the program.

—That appropriate individuals who could serve on technical assistance advisory panels be identified in order that they may be called upon to provide assistance to individual institutions, administrators, trustees and medical staffs.

—That funding be sought to cover necessary costs of accumulation of data, expenses of Steering Committee members and consultants, and expenses of the director of the program and any staff that he might require.

—That key officers and staff of the Medical Society and the Hospital Association be available for travel throughout North Carolina to explain this new program in individual communities and win support and participation in it.

(COMMENT on the most desirable location for the staff element for the Voluntary Program:

One alternative, a free-standing staff reporting only to the Steering Committee and not attached to any single provider

or related group comprising the Steering Committee. Advantages would be possibly greater public acceptance of staff activities and leadership from a neutral locus; desirability for the Steering Committee to have an impartial, detached staff; and avoidance of a possible adversary relationship that could develop between individual hospitals and the North Carolina Hospital Association if the program were located in NCHA.

Advantages for locating the staff support within the Hospital Association would be the likelihood of greater acceptance by the institutional NCHA members for the program; better liaison between the American Hospital Association, NCHA and individual hospitals; increased opportunity for attracting and retaining a qualified staff person; greater facility in providing for personnel costs and office space; and improved general oversight of the program on a day-to-day basis.

Following extensive discussion, the persons preparing this report agreed that location within the Hospital Association would be the more desirable, at least initially, because the advantages seemed to carry more weight.)

## TENTATIVE BUDGET

The tentative budget presumes a professional staff position of a person with a sound hospital financial background.

The travel and per diem budget estimates based on the presumption that an advisory screening panel — of perhaps an administrator, physician, trustee and one other person — would be utilized to visit various communities for consultation and review of budgets and expenditures on a selected basis. The budget presumes one overnight trip a week for four persons on an average round trip distance of 200 miles, for a period of 40 weeks.

Thus, the major budgetary elements are as follows:

1. Salary of Staff Director .....	\$25,000
2. Staff support and office .....	25,000
3. Travel and necessary per diem .....	25,000
	<hr/>
	\$75,000

If only limited funding became available, then perhaps the NCHA would find it necessary to fund the salary of the director and the staff, office and support funds on an in-kind contribution, and that perhaps philanthropic support could be obtained also. Foundation support was also suggested for funding for travel and per diem.

Other suggestions were to the effect that additional funding might also be obtained from Blue Cross and commercial insurers.

It was agreed that the program should be initially established on a two-year basis.

The Medical Society might also offer some in-kind assistance in the way of printing facilities and mailings.

(Adopted. See page 64.)

## RESOLUTIONS

SPEAKER LYMBERIS: Thank you, Dr. Carr.

You have before you the Resolutions which have been presented in time to be included in your packet. These Resolutions will be referred to the Reference Committees as indicated in your agenda.

There are two late Resolutions and in order for a late Resolution to be received by this House, it must have the two-thirds approval of the House.

But, prior to introducing that, I should give you an opportunity — a Resolution may be withdrawn by its sponsor at this point. Once the Resolution has been received by this House, it becomes the property of this House and may not be withdrawn.

Is there any sponsor of a Resolution who desires to withdraw or amend his Resolution prior to it being received by the House? [No response].

Hearing none, these Resolutions are accepted by the House as the business of the House.

There are two late Resolutions introduced by Edgecombe-Nash. Will the representative from Edgecombe-Nash go to a microphone?

Dr. Bailey, what is the nature of these Resolutions?

DR. LLOYD W. BAILEY [Edgecombe-Nash County]:

One is a Resolution to, really the idea is to have the proposal for a change in the Code of Ethics debated here before our Society so that we will all have an opportunity to discuss them and then perhaps give a feel to our delegates who are going to the AMA in June, so these will come up there and we felt these matters needed to be discussed.

SPEAKER LYMBERIS: Is it the will of the House to accept late Resolution "A"?

[Whereupon a motion and a second was made from the floor.]

All in favor raise your hand please!

This constitutes a two-thirds majority. Late Resolution A will become Resolution No. 16 and will be sent to Reference Committee I.

(See page 61. Resolution 16.)

DR. BAILEY: The second resolution deals with the National Commission on the Cost of Medical Care.

I don't know how many of you are familiar with the findings of this commission. This will also be discussed by the AMA when it meets in June and we feel that it is very important for us to discuss this.

To give you about sixty seconds worth of background on this, the commission's findings do not find inflation or government interference among the causes of rising health care costs.

SPEAKER LYMBERIS: This is the nature. We will not discuss it here. Is it the will of the House to accept late Resolution "B"?

DR. ROBERT MILLER [Mecklenburg County]: So moved.

[Whereupon a motion and a second was made from the floor.]

SPEAKER LYMBERIS: All in favor please raise your hands! This is better than two-thirds majority. Late Resolution B will become Resolution No. 17 and will be sent to Reference Committee I.

(See page 61. Resolution 17.)

Gentlemen, the Reference Committees will meet tomorrow afternoon. I do urge you to attend these Reference Committees even if you have no particular thing to say. You will certainly be educated in the content of these resolutions, as well as those things which may have been left out of Resolutions.

But your best opportunity for a better understanding of the business of this House is to attend the Reference Committees. These committees need your input and by going to these committees, you contribute directly and greatly to the business of this Society.

#### Resolution: 1

INTRODUCED BY: Franklin County Medical Society  
SUBJECT: Opposition to any Type of National Health Insurance including Proposal by AMA

REFERRED TO: Reference Committee II

WHEREAS, we believe world wide experience in nationalized health service has always resulted in increased cost and lower standard of patient care, therefore be it

RESOLVED, that the North Carolina Medical Society, as several other state societies have done, go on record as being totally opposed to any type of national health insurance including the proposal presented by the American Medical Association.

(Not adopted. See pages 68-71. Reference Committee substitute adopted in lieu of Resolutions 1, 3 and 15.)

#### Resolution: 2

INTRODUCED BY: Wake County Medical Society

SUBJECT: Compulsory Continuing Education

REFERRED TO: Reference Committee I

WHEREAS, the North Carolina Medical Society is an organization of qualified professional medical scientists and,

WHEREAS, the continuing education process is inherent in the day-to-day activities of a professional and,

WHEREAS, there is no evidence of a general deficiency in performance of medical scientists due to lack of education and,

WHEREAS, there is no evidence to indicate that any isolated deficiency in performance will be corrected by compulsory continuing education and,

WHEREAS, in spite of the fact that broad simplistic programs such as compulsory continuing education are appealing to governmental agencies and organizations and,

WHEREAS, these programs in the end create an atmosphere where documentation of educational activities becomes an end in itself without regard to affecting performance of the professional, be it

RESOLVED, That the North Carolina Medical Society rescind the requirement for compulsory continuing education, and be it further

RESOLVED, That the North Carolina Medical Society shall disassociate itself from any policy or activity that endorses or condones compulsory continuing education.

(Not adopted. See page 65.)

#### Resolution: 3

INTRODUCED BY: Edgecombe-Nash County Medical Society

SUBJECT: Opposition to All Forms of Socialized Medicine or National Health Insurance

REFERRED TO: Reference Committee II

WHEREAS, the Department of Health, Education, and Welfare is a formidable adversary and does not need the assistance of organized medicine in its efforts to socialize medicine,

WHEREAS, the American Medical Association should represent its members and further the preservation of the freedom to practice medicine without government interference and controls instead of acting as the Department of Health, Education, and Welfare's auxiliary as it is now doing, therefore be it

RESOLVED, That the House of Delegates of the North Carolina Medical Society direct our delegates to the American Medical Association to oppose any and all forms of socialized medicine or national health insurance.

(Not adopted. See pages 68-71. Reference Committee substitute adopted in lieu of Resolutions 1, 3 and 15.)

#### Resolution: 4

INTRODUCED BY: Section on Ophthalmology

SUBJECT: The Society Condemn the Practice by Ophthalmologists of Participation in Optical Profits

REFERRED TO: Reference Committee I

WHEREAS, secret or concealed profit-making by an



Ophthalmologist from optical dispensing is clearly not ethical because it is not in the best interest of the patient or the medical profession, and

WHEREAS, secret rebates, secret kick-backs, secret commissions, concealed profits accruing from the giving of professional advice, and the like, are widely condemned by all professions worthy of the name, and are dishonest in the eyes of honest men, now therefore be it

RESOLVED, That this Society condemns in the most unequivocal terms the practice by Ophthalmologists of participation in optical profits, without the full knowledge of the patients prescribed for, and by full knowledge we mean that any patient of mediocre intelligence must be able to know WITHOUT HAVING TO INQUIRE that the practitioner has a financial interest in the dispensing facility, be it further

RESOLVED, That the members of this Society are not only authorized by the Society, but charged with the duty, to bring about compliance with the AMA code of ethics by Ophthalmologists who violate this principle of ethics. Where friendly and uncensorious approaches to an offending colleague fail to achieve results, recourse to charges of unethical conduct before the County Medical Society will have to be the method of last resort.

(Amended by Reference Committee substitute Resolve and adopted. See page 65.)

#### Resolution: 5

INTRODUCED BY: Durham-Orange County Medical Society

SUBJECT: Encourage Greater Participation of the State of North Carolina in the Selection of Communities for Federal Health Programs

REFERRED TO: Reference Committee I

WHEREAS, the State of North Carolina has developed several major programs\* to help communities improve the distribution of physicians and support personnel; and

WHEREAS, these activities have broad community and professional support and show early signs of overcoming the problem of inequitable access to health care services; and

WHEREAS, the federal government has the need to find placement for an increasing number of National Health Service Corps (NHSC) physicians and other personnel and for other programs such as the Rural Health Initiative (RHI) Program and the Health for Underserved Rural Areas (HURA) Program; and

WHEREAS, the federal government is constrained to developing its placements through offices based in Atlanta without the needed familiarity with North Carolina communities and without the technical assistance resources provided by state supported programs already working to improve distribution of physicians and other personnel,

NOW, THEREFORE, the North Carolina Medical Society hereby resolves to support the North Carolina Secretary of Human Resources in pursuing all steps necessary to effect a partnership between the state and federal governments which provides a greater opportunity for the state to participate in the selection, development, and support of NHSC, RHI and HURA sites, it is further

RESOLVED, That such arrangements will allow federal programs to be developed with a minimum of disruption of North Carolina's communities, with a maximum of interaction with the State's own health manpower development programs, and with a greater likelihood for long term viability of the sites;

\*North Carolina Programs include: Office of Rural Health Services, Area Health Education Centers Program, Regional Perinatal Program, etc.

FINALLY, it is resolved that the North Carolina Medical Society supports efforts to improve physician distribution and will be closely associated with the Secretary in these efforts.

(Adopted. See page 65.)

#### Resolution: 6

INTRODUCED BY: Pitt County Medical Society  
SUBJECT: Change Deadline for Submitting Resolutions to North Carolina Medical Society Headquarters Office from Thirty Days to Sixty Days

REFERRED TO: Reference Committee I

WHEREAS, each year the issues of importance arise from component societies in form of resolutions; and

WHEREAS, the House of Delegates has in previous years set a minimum of thirty (30) days before its meeting for submission of resolutions; and

WHEREAS, the North Carolina Medical Society Headquarters receiving these resolutions need two weeks to sort, organize and prepare them for mailing to the Delegates; and

WHEREAS, this time frame does not allow component societies to review these resolutions with the Delegates at a regular Society meeting before the House of Delegates; and

WHEREAS, this system forces Delegates to make decisions without benefit of Society members' input, be it therefore

RESOLVED, That the Delegates change the deadline for submitting resolutions to the North Carolina Medical Society to sixty (60) days so that the Delegates have ample opportunity to review resolutions and present them to their component societies for study and criticism thus allowing better participation of component societies in the final decision which takes place on the floor of the House of Delegates.

(Adopted. See page 65.)

#### Resolution: 7

INTRODUCED BY: Pitt County Medical Society  
SUBJECT: Support the Recommendation of the OMB (Federal Office of Management and Budget) that Funds for PSRO be Dropped

REFERRED TO: Reference Committee II

WHEREAS, a recent study by Health, Education and Welfare reveals no benefit or savings to the taxpayers resulting from PSRO; and

WHEREAS, the Federal Office of Management and Budget (OMB) has recommended that no funds be included for PSRO in the proposed budget for the coming fiscal year; be it therefore

RESOLVED, That this Society support the OMB in its recommendation that funds for PSRO be dropped from the budget; and be it further

RESOLVED, That a copy of this resolution be introduced to the next session of the House of Delegates of the North Carolina Medical Society.

(Filed. Not adopted. See page 71.)

#### Resolution: 8

INTRODUCED BY: Alamance-Caswell County Medical Society

SUBJECT: Instruct Editorial Board to Terminate the Acceptance of Ads for Cigarettes and Tobacco Products in *North Carolina Medical Journal*

REFERRED TO: Reference Committee I

WHEREAS, we, the North Carolina House of Delegates hereby declare that it is inappropriate for a journal of the

medical profession to carry ads for a known health hazard, be it

**RESOLVED**, That we, as members of the health profession and as members of the North Carolina Medical Society, instruct the Editorial Board of the *North Carolina Medical Journal* to terminate the acceptance of ads for cigarettes and tobacco products in the *North Carolina Medical Journal*.

(Not adopted. Amendment proposed by the Reference Committee as substitute Resolve was not accepted see page 65, and upon consideration of original resolution it was also defeated, see page 67.)

#### Resolution: 9

**INTRODUCED BY:** Catawba County Medical Society  
**SUBJECT:** Change deadline for Submitting Resolutions to North Carolina Medical Society Headquarters Office from Thirty Days to Sixty Days

**REFERRED TO:** Reference Committee 1

**WHEREAS**, Delegates of county medical societies are the elected representatives who express and vote the sentiments of the physicians in each county, and

**WHEREAS**, all Delegates should be thoroughly instructed by the membership before coming to the Annual House of Delegates Meeting, and

**WHEREAS**, the present rules of North Carolina Medical Society states that all resolutions be submitted thirty (30) days prior to Annual Meeting, and

**WHEREAS**, this does not give adequate time for consideration of resolutions by the membership of each county society before the House of Delegates meeting, therefore be it

**RESOLVED**, That all resolutions (except late resolutions) be submitted sixty (60) days prior to the Annual Meeting, thereby giving time for all resolutions to be thoroughly discussed at the county level and the Delegates to be properly instructed.

(Filed. Intent of resolution adopted and superseded by adoption of Resolution 6.)

#### Resolution: 10

**INTRODUCED BY:** Catawba County Medical Society  
**SUBJECT:** Support of Position Paper Regarding Primary Care in County Health Departments

**REFERRED TO:** Reference Committee 11

**WHEREAS**, the 1977 General Assembly allocated \$2.75 million, to be expended over the next biennium, in the form of grants to county health departments, to enable them to provide "primary health care services" to patients in their area of service, and

**WHEREAS**, the Executive Council of North Carolina Medical Society has thoroughly considered and reviewed the proposed program on repeated occasions, and

**WHEREAS**, the Executive Council issued a position paper on 2-16-78 expressing the opinion that the program was not in the best interest of patients and proposed patients of such health departments, therefore be it

**RESOLVED**, That the unanimous support of the House of Delegates be given this position paper, and this action along with adequate explanation be presented to the Governor, the General Assembly and the Media.

(Amended by Reference Committee substitute Resolve, see page 71, followed by floor amendment by addition, see page 71, and adopted see page 71.)

#### Resolution: 11

**INTRODUCED BY:** Catawba County Medical Society  
**SUBJECT:** Opposition to the proposed North Carolina

Health Planning and Certificate of Need Law for 1978 General Assembly

**REFERRED TO:** Reference Committee 11

**WHEREAS**, the cost of quality medical care is not cheap, but comparable to other inflationary rate, and

**WHEREAS**, the high cost of medical care is continually played up in the news media as somehow being the fault and responsibility of the medical profession, and

**WHEREAS**, it is our opinion that it is the Government itself which is responsible for the inflation and the propaganda for this false blame on the medical profession, and

**WHEREAS**, the proposed "North Carolina Health Planning and Certificate of need Law of 1978" prepared for the May 1978 Session of the North Carolina General Assembly will deliver to the State Department of Human Resources full control over any proposal to build or enlarge any hospital, nursing home or physician office or the purchase of any equipment by any hospital, nursing home or physician's office, if the cost, exceeds more than \$100,000, without first securing certificate of need, and

**WHEREAS**, as such a law would be blatantly unfair, probably unconstitutional and an infringement of personal freedom or an attack on free enterprise, the foundation of this country, therefore be it

**RESOLVED** (1) That the Catawba County Medical Society goes on record as being opposed to this proposed law, and

(2) Respectfully, requests the North Carolina Medical Society to publicly express its opposition and work to keep it from reaching the floor of the General Assembly, and

(3) If it does reach the General Assembly, that aggressive effort be expended to cause its defeat, but

(4) If passage seems imminent that the individual physicians be encouraged to use whatever legal means available to cause its defeat or repeal as an expression of our having reached the point of disgust with Government intervention in the private sector without making some effort to set "their own" house in order.

(Amended by Reference Committee substitute Resolve and Adopted. See page 72.)

#### Resolution: 12

**INTRODUCED BY:** Cumberland County Medical Society  
**SUBJECT:** Reporting Drug Abuse to Local Health Departments

**REFERRED TO:** Reference Committee 11

**BE IT RESOLVED**, That the North Carolina Medical Society recommends that Drug Abuse, i.e.: intoxication or addiction, be a reportable illness to local Health Departments much as are communicable diseases, and that drug related crime is a reportable illness to local Health Departments by law enforcement agencies, the purpose of this being to obtain data for epidemiological and statistical evaluation.

(Not adopted. See page 72.)

#### Resolution: 13

**INTRODUCED BY:** Forsyth-Stokes- Davie County Medical Society

**SUBJECT:** Proposed Expansion of Treatments of Cancer Sponsored Under the State Cancer Diagnosis and Treatment Program

**REFERRED TO:** Reference Committee 11

**WHEREAS**, there have been significant advances in the treatment of cancer in the last five years, and

**WHEREAS**, the Cancer Diagnosis and Treatment Program of the State of North Carolina has defined that patients



who have cancer that have a "reasonable chance" for cure or arrest are eligible for assistance, and

**RESOLVED**, That the treatments which can be sponsored for payment under the State Cancer Diagnosis and Treatment Program be expanded to include:

1. Acute Lymphoblastic Leukemia in children.
2. "Adjuvant" therapy for soft-tissue and bone sarcomas.
3. Non-Hodgkin's Lymphoma, all stages.
4. Hodgkin's Disease, Stage IV.
5. Testicular Cancer, all types and stages.
6. Polycythemia vera.
7. Malignant Melanoma, Clarks Level I-III.
8. Stage I Carcinoma (TNM) of Lung and Esophagus.

**RESOLVED**, that an Oncology Advisory Committee composed of Medical, Surgical, and Radiation Oncologists be appointed to advise and consult with the Cancer Committee of the North Carolina Medical Society.

(Filed. See page 72.)

#### **Resolution: 14**

**INTRODUCED BY:** Craven-Pamlico-Jones County Medical Society

**SUBJECT:** Non-Confidentiality of Information on Current Certificate of Live Birth

**REFERRED TO:** Reference Committee II

**WHEREAS**, the present Certificate of Live Birth requires the physician to divulge confidential information, examples:

- a. educational status of both parents
- b. race or color of both parents
- c. number of pregnancies
- d. marital status of mother
- e. complications of pregnancies
- f. complications of labor and delivery
- g. congenital malformations or abnormalities of child

**WHEREAS**, it is recognized that the information requested may yield statistically rewarding data.

**WHEREAS**, the confidentiality of such information is not assured,

**WHEREAS**, absolute integrity of the patient-physician relationship must be maintained without inappropriate breach of confidentiality,

**WHEREAS**, because of the above, invalid conclusions may be drawn from inaccurate data,

**WE DO HEREBY** offer the following resolution: The present Certificate of Live Birth be changed so that confidentiality of such information can be assured.

(Amended and adopted. See page 72. Reference Committee substitute adopted.)

#### **Resolution: 15**

**INTRODUCED BY:** Forsyth-Stokes-Davie County Medical Society

**SUBJECT:** Comprehensive Health Insurance Act

**REFERRED TO:** Reference Committee II

**WHEREAS**, the American Medical Association has consistently urged that any national health insurance should build on existing private insurance and not be operated as a government service, should be financed by private payments from those able to pay and from general tax funds for low income groups, should utilize our pluralistic health care systems, should be comprehensive, should have minimal federal involvement and should not be financed by a payroll tax nor administered under Social Security; and

**WHEREAS**, the American Medical Association has a responsibility not only to the medical profession, but to the public and the Congress to support these principles; and

**WHEREAS**, the American Medical Association has sponsored in the Congress The Comprehensive Health In-

surance Act of 1977 (HR 1818) to embody these principles, and thus be able to enter into all discussions and hearings on national health insurance; therefore be it

**RESOLVED**, That the North Carolina Medical Society affirm its support of the American Medical Association in sponsoring legislation on national health insurance which embodies the American Medical Association's principles in the maintenance of a major role for the private sector.

(Amended and adopted. See pages 68-71. Reference committee substitute adopted in lieu of Resolutions 1, 3 and 15.)

#### **Resolution: 16 (Late Resolution A)**

**INTRODUCED BY:** Edgecombe-Nash County Medical Society

**SUBJECT:** Opposition to Proposed Changes in the Code of Ethics of the American Medical Association

**REFERRED TO:** Reference Committee No. I

**WHEREAS**, the Judicial Council of the American Medical Association has proposed radical changes in the Code of Ethics of the American Medical Association, especially Articles V and VI, supposedly "intended to clarify and update the language of the Principles," and

**WHEREAS**, the changes proposed in Article VI compromise a physician's free and independent exercise of his medical judgment and condone the unconstitutional modification of the doctor-patient contract by third parties, especially agents of the federal government, and

**WHEREAS**, changes proposed in Article V would now permit solicitation of patients, action previously strictly prohibited and considered unethical, therefore,

**BE IT RESOLVED**, That the Edgecombe-Nash County Medical Society expresses opposition to the changes in the AMA Code of Medical Ethics, and

**BE IT FURTHER RESOLVED**, That the House of Delegates of North Carolina Medical Society direct the North Carolina Delegates to the American Medical Association to oppose these changes.

(Amended by Reference Committee substitute Whereas and substitute Resolve, see page 67, and adopted see page 67.)

#### **Resolution 17 (Late Resolution B)**

**INTRODUCED BY:** Edgecombe-Nash County Medical Society

**SUBJECT:** Opposition to the Findings and Recommendations of the National Commission on the Cost of Medical Care

**REFERRED TO:** Reference Committee No. I

**WHEREAS**, the recommendations of the National Commission on the Cost of Medical Care, which was sponsored and funded to the amount of \$400,000 by the American Medical Association, would increase government regulation of the medical profession and the delivery of medical care and would promote the public utility concept of medicine, therefore

**BE IT RESOLVED**, that the Edgecombe-Nash County Medical Society repudiates the findings and recommendations of the National Commission on the Cost of Medical Care, and

**BE IT FURTHER RESOLVED**, That we request the North Carolina Delegates to the American Medical Association to oppose the endorsement of these findings and recommendations.

(Amended by Reference Committee substitute Whereas and substitute Resolve, see page 67, and adopted see page 67.)

### COMMITTEE ON NOMINATIONS ELECTION OF DISTRICT MEMBERS

**SPEAKER LYMBERIS:** The next item of business is a recess for the District Caucus for the election of a committee on Nominations.

I would like to remind the caucus that in electing a member to the Committee on Nominations, the proposed member must be a delegate and he must be present. We will take a ten minute recess for the district caucus. The signs will tell you where your district is meeting. Districts two, six and ten should prepare to caucus. The meeting is temporarily recessed.

[Whereupon there followed a fifteen minute recess for the District Caucuses.]

Gentlemen, the three Districts have completed their caucus and as soon as you take your seats, we may proceed with the business of the House. Gentlemen, will the House please come to order?

We have the nominations from the three Districts where vacancies were present and I would like to ask the representatives from these Districts if each of these nominees is present and a delegate?

[Whereupon all three Districts responded in the affirmative.]

The nominees are:

Second District, Dr. Carl Hiller, New Bern;

Sixth District, Dr. George Cooper, Raleigh;

Tenth District, Dr. John Henderson, Asheville.

Are there any further nominations? [No response]

If not, do I hear a motion that these three be elected by acclamation? [Whereupon the motion was severally made and seconded from the floor.]

All in favor say "aye"; all opposed "no." They are elected.

The newly elected members of the Committee on Nominations and the present members of the Committee on Nominations will now assemble under a temporary chairman in Room #129 for their guidance and organization.

Is there any New Business to come before this House? [No response]

There being no further business, I declare the First Session of the House of Delegates adjourned.

[The meeting adjourned at three-thirty-five o'clock.]



# House of Delegates

## SECOND SESSION

### Abridged Minutes of the Meetings of the House of Delegates

ANNUAL MEETING — SECOND SESSION

SATURDAY AFTERNOON SESSION

May 6, 1978

The Second Meeting of the House of Delegates at the 124th Annual Meeting of the North Carolina Medical Society convened at two o'clock.

PRESIDENT ESTES: The Second Session of the House of Delegates will now be convened. I would like to turn the podium over to our Constitutional Secretary, Dr. Jack Hughes.

DR. JACK HUGHES [Secretary, Medical Society]:

At this time, we pause to remember our colleagues who have died during the past year. Their names are listed in the memorial pamphlet which you will find in front of you.

Will you all please stand!

Man that is born of woman hath but a short time to live and is full of misery. He cometh up and is cut down like a flower. He fleeth as if it were a shadow and never continueth in one stay. In the midst of life we are in death. Of whom may we seek for succor but of Thee, O Lord, who for our sins are justly displeased.

Yet, the Lord, God most holy, O Lord most mighty, O Holy and Most Merciful Saviour, deliver us not into the bitter pains of eternal death. Let us bow our heads for a brief period of silence and a closing prayer.

[Whereupon there followed a moment of respectful silence.] Almighty God, remember these our departed colleagues according to the favor which Thou bearest unto Thy people and grant that increasing in knowledge and love of Thee, they may go from strength to strength in the life of perfect service in Thy heavenly kingdom. Amen.

PRESIDENT ESTES: I would next like to introduce our distinguished Speaker, Dr. Marvin Lymberis, who will Chair the session for the remainder of the afternoon.

SPEAKER LYMBERIS: Thank you, President Estes. First, Dr. Payne, do you have a report for us from your Committee on Credentials?

DR. PAYNE: Mr. Speaker, there are 155 of the 213 delegates registered present in the room, which constitutes a quorum.

SPEAKER LYMBERIS: Thank you. The first thing to come before this House is the ratification of the Constitution and Bylaws and amendments.

The first reading of the Constitution was accomplished last year. Hearings have been held. It has laid over in the House and has again been referred to Reference Committee III, Dr. Jim Davis, Chairman. Dr. Davis, will you please present the recommendations of Reference Committee III?

#### REFERENCE COMMITTEE III

DR. JAMES E. DAVIS [Chairman, Reference Committee III]: Mr. Speaker, may the other members of the committee join me up front please. Dr. Dulin and Dr. Weeks.

Last year, the House received the first reading of the Revised Constitution. Reference Committee III re-submits this to the House with a recommendation for consideration of adoption, Mr. Speaker.

SPEAKER LYMBERIS: You have had a copy of the Revised Constitution and Bylaws in your packets to study.

Is this House now prepared to vote on the adoption of the new Constitution?

Hearing no objection, all in favor will please raise their hands.

The new Constitution is adopted.

#### REPORT C

and

#### Supplementary Report C

DR. DAVIS: Mr. Speaker, Reference Committee III submits five proposed amendments to our Bylaws with our recommendation for consideration of adoption as follows:

*Item 1:* Delete Section 3 of Chapter IV, page 4, and renumber the following section in numerical order. Mr. Speaker, we recommend this adoption.

SPEAKER LYMBERIS: Are there any questions regarding this change?

If not, all in favor say "aye"; opposed "no." It is adopted.

DR. DAVIS: *Item 2:* Amend Section 5(d), Editorial Board, of Chapter V on page 6 by changing the first word "Seven" to "Eight" so that the sentence will read:

Eight elective members of the Editorial Board of the *North Carolina Medical Journal* shall be elected by the House of Delegates to serve terms of four years. Mr. Speaker, we recommend adoption of this item.

SPEAKER LYMBERIS: Are there any questions regarding amendment number two?

If not, all in favor say "aye"; opposed "no." Item two is adopted.

DR. DAVIS: *Item 3:* Amend Section 2, Eligibility for Election, of Chapter VI on page 7 by adding as the next to the last paragraph of the section the following:

A member serving out the unexpired term of office of another member shall be eligible for re-election to that office. Mr. Speaker, we recommend adoption of this item.

SPEAKER LYMBERIS: Does any delegate have a question with regard to item three?

If not, all in favor say "aye"; opposed "no." Item three is adopted.

DR. DAVIS: *Item 4:* Amend Chapter IX on page 9 by deleting the name "Committee on Awards" from Section 3, by deleting the description of the Committee on Awards as Section 5, and by renumbering the remaining committees and sections in numerical order. Mr. Speaker, we recommend adoption of item four.

SPEAKER LYMBERIS: Are there any questions regarding item four?

If not, all in favor say "aye"; opposed "no." Item four is adopted.

DR. DAVIS: *Item 5:* Amend Chapter V, Section 4 on page 4 by changing one sentence in the body of the section to read as follows:

Each such component medical society shall be entitled to one delegate for its first twenty-five voting members or fewer and one additional delegate for each additional

twenty-five voting members or major fraction thereof, provided that in any event there shall be at least one delegate from each county, as specified in Chapter XI, Section 2.

Mr. Speaker, we recommend adoption of item five.

SPEAKER LYMBERIS: Are there any questions regarding item five?

If not, all in favor say "aye"; opposed "no." Item five is adopted.

DR. DAVIS: Mr. Speaker, Reference Committee III further recommends the publication of these documents in the *North Carolina Medical Journal* and recommends that additional copies be made available to our membership. Mr. Speaker, we so move.

SPEAKER LYMBERIS: All in favor of the motion as just read by the Chairman of the Reference Committee will say "aye"; opposed "no." It is adopted.

VICE SPEAKER CARR: Will the members of Reference Committee I please come forward?

Reference Committee I was chaired by Dr. E. Thomas Marshburn, Jr., of New Hanover and at this time, we are prepared to hear the report of Reference Committee I.

### REFERENCE COMMITTEE I

DR. E. THOMAS MARSHBURN, Jr. [Chairman, Reference Committee I]: Mr. Speaker and Members of the House of Delegates: Reference Committee I gave careful consideration to the several items referred to it and submits the following report:

### REPORT A

The first item of business was Report "A" the Annual Budget Estimates for 1978.

The Reference Committee reviewed the annual budget report and after discussion, your committee recommends that Report "A" of the Executive Council be approved.

VICE SPEAKER CARR: Is there any discussion regarding Report "A" of the Executive Council?

DR. DON C. CHAPLIN [Alamance County]: Don Chaplin of Alamance County! I wonder why we anticipate a thirty per cent rise in our legal fees this year? That's on "G" of miscellaneous. Are we anticipating some major problems?

DR. MARSHBURN: Delegate, this was brought up in the hearing and the rise, or rather the increases in all the costs was thought to be due to inflation, and other costs, and they have been figured into the budget for that particular reason. This was explained by Dr. Herring at the hearing and he may wish to talk about this at the present time.

DR. TILGHMAN HERRING [Wilson County; Chairman, Committee on Finance]: Dr. Herring of Wilson! Our legal fees were simply raised by our legal counsel! And, of course, it's a free economy and we can seek counsel elsewhere, but I think we've been getting excellent legal counsel and a great deal of personal attention and we feel that the fee has perhaps not gone up much beyond what medical costs have gone up.

DR. THOMAS B. DAMERON, Jr. [Wake County]: Tom Dameron! I'm on the Finance Committee also and one of the things that brought this up was the fact that it was in keeping with last year's budget. We overspent in this regard as you will notice in looking at the financial statement and much of this was due to legislative matters, that our President alluded to in his presidential address. We have had a great deal more expenses in this regard.

DR. ARCHIE T. JOHNSON, Jr. [Section on Pediatrics; Chairman, Committee on Legislation]: I'm Archie Johnson of Wake County. I would like to speak to that, also. I hope I don't have to give my credentials as a fiscal conservative, but I was involved with the discussion relating to the fees

because a lot more time this past session was required in terms of legislative involvement, and a lot more will be required in the future. I think you can tell from the issues that are before us.

So, it's more a matter of person power, if you would, and that is one of the reasons, I think, for the increase.

DR. CHAPLIN: I think that we all recognize the need for legal counsel and support and thirty percent may be a justified raise in the budget. We do not anticipate, I would think, with the very short legislation of this year that the lobbyist effort might consume large quantities of both time and money.

I think we need to look at this problem a little more closely as the years approach because we certainly have not raised our fees, at least I certainly have not, thirty per cent in one year, nor has my overhead gone up significantly in that amount. I appreciate the opportunity to call that to the attention of this body.

VICE SPEAKER CARR: Is there any further discussion of this report?

If not, all those in favor of the report please say "aye" opposed "no." The report is adopted.

### REPORT E

DR. MARSHBURN: Report "E" — Policy statement supporting the use of approved automobile child restraint for children aged one to five. Mr. Speaker, Reference Committee I recommends that Report "E" of the Executive Council be approved.

VICE SPEAKER CARR: Is there any discussion of Report "E" of the Executive Council?

If not, all those in favor of Report "E" please say "aye" opposed "no." The report is adopted.

### REPORT G

DR. MARSHBURN: Report "G" — Recommendation for implementation of a voluntary cost containment program in North Carolina. Mr. Speaker, Reference Committee I recommends approval of this report of the Executive Council.

VICE SPEAKER CARR: Is there any discussion of Report "G" of the Executive Council?

All those in favor of Report "G" please say "aye"; opposed "no." The report is approved.

### RESOLUTION 2

DR. MARSHBURN: Resolution No. 2 — Compulsory continuing medical education, presented by Wake County.

Your Reference Committee heard considerable discussion concerning this resolution. The committee reached the conclusion that while there are perhaps flaws in our compulsory medical education ruling, we feel that as young as it is, these can be worked out in the future. Mr. Speaker, Reference Committee I recommends that this resolution be rejected.

DR. DAMERON: I'm Tom Dameron again from Wake County! The Wake County Resolution was really the work of Al Chasson who had to be away now because he was involved with the Pathology Section and their guest speaker but he was Chairman of the Committee on Continuing Medical Education of the North Carolina Medical Society and he had many frustrations as such and he did propose this to our county society for three reasons.

The three reasons brought to our county society were number one, that at the end of this last calendar year when the time has run out, I think there were about 1500 members of the Society who were going to be ineligible for membership.



It's my understanding that this has come down considerably now, but it was the concern of the Wake County Medical Society as to what would happen to the North Carolina Medical Society if we did lose 1500 members. The proportion of dues raised and the effectiveness of the organization might be hurt accordingly. It is my understanding that this figure has now come down to 600, but this is one of the reasons.

The second reason was, as brought out in the discussion yesterday, the relative ineffectiveness of the continuing medical education as we have. I don't think we need to get into any great details there, but it is realized that in order to make it more effective, it would be more complex and it would be much more distasteful, so I don't think this is really a big concern.

The third thing that I think concerned many of the people in the Wake County Medical Society was the word "compulsory." Doctors being as they are, I think there's nothing that will raise the red flag more quickly than to tell people they've got to do something and these are the three reasons that it was passed by the Wake County Medical Society.

VICE SPEAKER CARR: Is there any further discussion regarding Resolution No. 2?

If not, all those in favor of Resolution No. 2 please say "aye"; all those opposed please say "no." The Chair rules that the resolution is defeated.

#### RESOLUTION 4

DR. MARSHBURN: The next item of business is *Resolution No. 4* — The Society condemn the practice of ophthalmologists of participation in optical profits.

Mr. Speaker, after hearing discussion on the resolution, Reference Committee I would like to amend it to read as follows; changing the RESOLVED to read thusly:

RESOLVED, that optical dispensing facilities owned wholly or in part by a physician or a group of physicians shall not be operated in a manner designated to exploit the patient, to conceal the ownership, or mislead the patient in any manner.

VICE SPEAKER CARR: We will vote on the amended motion first. Now, is there any discussion of the amended motion?

If there is none, all those in favor of the amended motion please say "aye"; opposed "no." The Chair rules that the amended motion passes.

#### RESOLUTION 5

DR. MARSHBURN: The next item of business is *Resolution No. 5* — Encourage greater participation of the State of North Carolina in the selection of communities for federal health programs presented by Durham-Orange County. Mr. Speaker, Reference Committee I recommends that Resolution No. 5 be approved.

VICE SPEAKER CARR: Is there any discussion regarding Resolution No. 5?

All those in favor of Resolution No. 5 please say "aye"; opposed "no." The motion carries.

#### RESOLUTION 6

DR. MARSHBURN: The next item is *Resolution No. 6* — Change Deadline for submitting resolutions to North Carolina Medical Society headquarters office from thirty days to sixty days. Mr. Speaker, Reference Committee I recommends Resolution No. 6 be adopted.

VICE SPEAKER CARR: Is there any discussion regarding Resolution No. 6?

All those in favor of Resolution No. 6 please say "aye"; opposed "no." The motion passes.

#### RESOLUTION 9

DR. MARSHBURN: The next item is *Resolution No. 9* which is similar to Resolution No. 6. Mr. Speaker, Reference Committee I recommended that this resolution be filed. The intent of Resolution 9 was adopted and superseded by your earlier adoption of Resolution 6.

VICE SPEAKER CARR: Is there any discussion of Resolution No. 9?

All those in favor of Resolution No. 9 being filed please say "aye"; opposed "no." The resolution will be filed.

#### RESOLUTION 8

DR. MARSHBURN: *Resolution No. 8*: Instruct Editorial Board to terminate the acceptance of ads for cigarettes and tobacco products in the *North Carolina Medical Journal*.

Reference Committee I, after hearing discussion from those attending, recommends that this resolution be amended to read as follows:

RESOLVED, that we, as members of the health profession and as members of the North Carolina Medical Society, support the Editorial Board of the *North Carolina Medical Journal* in the publication of its disclaimer to be printed in the masthead of the Journal: "The appearance of an advertisement in this publication does not constitute any endorsement of the subject or claims of the advertisements."

DR. CHAPLIN: Don Chaplin, Alamance County. Our county delegation felt very strongly that the health profession at large for many years has recognized the hazards of smoking, has been the foremost people who have pushed to educate our population of its danger and to encourage them not to smoke.

We feel like it's inappropriate for the Editorial Board to continue to accept advertisements of this nature and that we should take a very affirmative step to instruct them not to do so. We recognize that this body cannot actually dictate to the Editorial Board what it does. It is apparently somewhat independent, but would be very receptive to our own discussions.

I do feel that the disclaimer is an opportunity in the right direction, but this Journal because we do accept certain advertisements, does give a tacit support, or at least a gold seal of approval that it is an accepted product. I know a lot of us have some strong feelings about that statement, but I feel like that's what it represents.

This Journal is distributed not only to physicians but to certain libraries and is subject to being shown by the P. R. men of the cigarette advertising companies. We know that it's not a matter of money, that there are adequate people seeking advertising space in our Journal. We also recognize that the Editorial Board does scrutinize advertisements to decide what is appropriate.

I, for instance, cannot run a megavitamin for the cure of cancer, nor to promote such techniques as human gonadotropin hormone injections for weight control because, apparently, there is at least some medical ethics involved in health hazards.

Therefore, I recommend to this body to consider strongly rejecting the committee's recommendation so that we might consider the original resolution presented by my county society.

DR. HAROLD R. SILBERMAN [Durham-Orange County]: Dr. Silberman of Durham-Orange County! I'm going to preface my remarks by saying I'm a medical oncologist and a cigarette smoker, and an asthmatic!

We won't accomplish anything by eliminating cigarette ads from the Journal. If we've abrogated our responsibility as physicians, it's again in the field of education. There is no

evidence that a half a pack of cigarettes a day leads to cancer and certainly, a pack a week is very safe. The analogy could be applied to liquor as well. There are many people who would be better off smoking four cigarettes a day, than eating all that valium and librium and I'm one of them.

Very few heavy smokers read this Journal, other than physicians and they've been reformed. We won't accomplish anything with this resolution. We will hurt the financial underpinning of the Medical Journal and such a proposal ignores the crucial issue and which the government has ignored. The crucial issue is how to revise a large portion of the North Carolina agrarian economy while phasing out the excessive — and I underline the word "excessive" — cropping of tobacco.

We don't need to smoke three packs a day. I need to smoke five or six packs a day and I intend to do so and I would think it silly to eliminate cigarette ads from any magazine or any television set, for that matter.

DR. NORMAN J. ROBINSON [New Hanover County]: I'm Norman Robinson from New Hanover County! I don't know whether this is the appropriate place to discuss or debate the hazards or lack of hazards of cigarette smoking.

Certainly, I think it has been clearly shown that cigarette smoking is a risk factor for the development of cardiovascular diseases.

I do feel that we have a moral obligation to voice our support for those principles which we feel are in the best interest of our patients and I think by our not having the tobacco advertisements in our own Journal, this is one way of reinforcing our support of what we consider to be in the best interest of our patients. So, I would strongly support the original proposal and would hope that we would vote down the amendment so we can then voice our support for the original proposal.

DR. JAMES S. WARD [Iredell County]: I'm James Ward from Iredell County! Food can also be harmful to your health.

Some of us are walking health risks, by our being overweight, we know! I would not in any sense claim that eliminating food ads from the Medical Journal will make us slender or revise our eating habits, or cure the habits of our obese patients.

There is no product on the face of the earth that cannot be abused by mankind in one way or another. There are certain products, however, which have very few if any legitimate uses. Not to argue with my colleague who preceded me two speakers ago, but I think there are reasonable alternatives to smoking.

Valium and librium may, for an unfortunate few, be some of them, but abstinence is possible too. I am, myself, a "quit smoker."

I wouldn't claim that eliminating cigarette ads is going to make other people stop smoking, or in any way revise the smoking habits of any members here who know the risks and continue to smoke, whatever the amount.

I don't think the debate is over how many cigarettes you can smoke a day and be safe, either. We probably don't know, but if we do, that isn't the subject of this amendment. If the Journal continues to accept cigarette smoking ads, we are tacitly giving approval to the smoking of cigarettes.

The question boils down to whether we want to or not. I, for one, don't think we should. I feel if the amendment as proposed would eliminate our voting on the original resolution to eliminate cigarette ads from our Journal, then it should be voted down so that the original resolution can be brought to the floor. I would like to see that resolution passed myself.

DR. G. THOMAS A. MORRIS [Alamance County]: Tom

Morris from Alamance County! I would like to speak against the committee's recommendation because I really don't think we need a disclaimer on the masthead of our Journal. That's a journalistic device that's really of little use to our Society.

So, I would like to oppose the committee's recommendation. I don't have a position in favor of telling people not to smoke, or our profession. This was voted in our Society and it was a near unanimous vote but not a unanimous vote and I think this will also be voted by this membership in a way that reflects the majority opinion of the delegates present.

VICE SPEAKER CARR: Is there any further discussion regarding the amended motion?

If not, all those in favor of the amended motion, please say "aye"; opposed "no." The Chair rules that the motion is defeated, that is, the amended motion is defeated and now we're back to the original resolution as submitted from Alamance County Medical Society.

DR. JOHN T. DEES [Pender County]: As a former asthmatic and as a former cigarette smoker, I want to say I think a resolution to do away with cigarette advertising, or any other advertising, in our Journal or any other journal is against the very principles that we as physicians fight for every day.

By golly, we met here last night, those of us who came to the MEDPAC dinner, and we said, "Doctors, get out and get busy; participate and be good citizens and let's have free enterprise!" And, then we come here this afternoon and we say to the tobacco companies, "You can't advertise in our medical journal because we think it's bad to smoke!" I think it's bad to smoke, but I don't think it's bad to advertise in our Journal.

DR. DAMERON: This is Tom Dameron from Wake County. I think there's one issue that's of paramount importance — it really hasn't been brought up — and that is the House of Delegates instructing the Editorial Board what they should do and what they should not do.

Unless there is absolute conclusive proof that moderate use of cigarette smoking is really harmful, you get into many technical things — for instance, would it be wise to tell people who are going to smoke to smoke the low nicotine cigarettes? Would that be a good thing or not?

There are so many little technical things that get into this, in addition to the political interests. The economic issue is of no consequence here. But I think the overall principle of this House of Delegates instructing the Editorial Board on procedure is very unhealthy and hence, I'm opposed to this resolution.

DR. JESSE CALDWELL [Gaston County]: Mr. Speaker, Jesse Caldwell from Gaston County! I do not believe that anywhere in our Constitution and Bylaws that this House of Delegates can tell the Editorial Board what to do. Now, we elect the Editorial Board and if we don't like what they do, we can not elect the same board the next time it comes around, but I don't believe this House of Delegates can dictate to the Editorial Board of the *North Carolina Medical Journal*.

DR. SILBERMAN: In the exigency that a substitute motion doesn't pass, does the Reference Committee have prepared their original opinion on the original motion and, if so, can they give it to us?

VICE SPEAKER CARR: Unless they wanted to discuss it as a member of the House of Delegates and not as a Reference Committee — they've already rendered their opinion as a Reference Committee, per se.

DR. SILBERMAN: Then we interpret their opinion that the ad should be in and the masthead indicate that we don't necessarily endorse every ad in the Journal. Is that right?



VICE SPEAKER CARR: That's what they said, yes.

DR. SILBERMAN: I just wanted to bring that out for emphasis. I just would like to reiterate what I've said and comment that I do want to underscore that abstinence is the solution to only one problem and that's birth control! If I wanted abstinence, I'd become a monk and not a doctor!

The matter is critical! It's a matter about educating about excess. It is harmful to smoke too much. That's all we've ever proven as scientists and we go beyond our scientific base when we try to extrapolate from that anything else.

It is harmful to smoke too much!

It is harmful to eat too much!

It is harmful to read *Playboy* too much!

It is harmful to drink liquor too much!

And, it's harmful to make mistakes too much!

If and when we wanted to put the ad back in the Journal, it would look like we were endorsing smoking if we did advertising and that day would come that we put this ad back. It's the old business of doing something which you want to revise and then you get more attention than you intended. I don't think you accomplish anything with that kind of advertising. If you want to accomplish something, you have to get out and educate the patients.

VICE SPEAKER CARR: Dr. Marshburn, did you want to speak as a delegate?

DR. MARSHBURN: Mr. Speaker, I would just like to say that Reference Committee I considered what has been spoken of already about telling the Board what to do and what not to do with regard to publication. But, in the Compilation of Annual Reports that you have received in your delegate packet, there's a copy of a report of the Editorial Board and then on the last page, on page 39, in the right hand column it states:

By action of the Board a disclaimer is to be printed in the Masthead of the Journal as follows:

"The appearance of an advertisement in this publication does not constitute any endorsement of the subject or claims of the advertisements."

This is what we have put in our resolve so that we do not in any way try to tell the Editorial Board what to do or how to run its business. This is taken verbatim from this report.

DR. THOMAS H. BYRNES, Jr. [Davidson County]: I'm Tom Byrnes from Davidson County! I rise to support fully Dr. Chaplin and the Alamance County resolution. However, it seems like we're hung up on the word "instruct" and I would wonder if the Alamance County would accept the word "advise" in lieu of the word "instruct."

VICE SPEAKER CARR: Do you offer that as an amendment to the resolution?

DR. BYRNES: I would offer that as an amendment to their resolution.

VICE SPEAKER CARR: Is there a second to that amendment?

DR. CHAPLIN: We so second.

VICE SPEAKER CARR: Is there any discussion with regard to the amendment to the resolution?

Dr. Marshburn, could you read that with the word, "advise," rather than "instruct"?

DR. MARSHBURN: RESOLVED, that we, as members of the health profession and as members of the North Carolina Medical Society advise the Editorial Board of the *North Carolina Medical Journal* to terminate the acceptance of ads for cigarettes and tobacco products in the *North Carolina Medical Journal*.

DR. CHAPLIN: We call for the question on the amendment!

VICE SPEAKER CARR: All those in favor of the amended Resolution No. 8 please say "aye"; opposed

"no." The Chair rules that the amended resolution fails.

We're back to the original Resolution No. 8.

Dr. Chaplin: Call for the question on that!

VICE SPEAKER CARR: All those in favor of Resolution No. 8 as stated originally please say "aye"; opposed "no." The Chair rules that the resolution fails.

## RESOLUTION 16

DR. MARSHBURN: The next item of business is *Resolution No. 16*. You might have it listed as late Resolution "A."

Resolution No. 16: Opposition to proposed changes in the Code of Ethics of the American Medical Association from Edgecombe-Nash County Medical Society. Mr. Speaker, Reference Committee I would like to recommend that Resolution No. 16 be amended to read as follows:

WHEREAS, the Judicial Council of the American Medical Association has proposed changes in the Code of Ethics of the American Medical Association, supposedly intended to clarify and update the language of the principles, therefore, be it,

RESOLVED, that the North Carolina Medical Society questions some of the proposed changes in the AMA Code of Medical Ethics, and be it further,

RESOLVED, that the North Carolina Medical Society reaffirms its stand against deceptive advertising as a means of attracting patients.

VICE SPEAKER CARR: Is there any discussion regarding the amended motion of the Reference Committee?

Hearing none, all those in favor of the amended motion of the Reference Committee say "aye"; opposed "no." The motion passes as amended.

## RESOLUTION 17

DR. MARSHBURN: The next item is *Resolution No. 17* otherwise called Late Resolution "B."

Resolution No. 17: Opposition to the Findings and Recommendations of the National Commission on the Cost of Medical Care. Mr. Speaker, your Reference Committee I recommends an amendment to this resolution to read as follows:

WHEREAS, the recommendations of the National Commission on the Cost of Medical Care, which was sponsored and funded by the American Medical Association, would increase government regulation of the medical profession and the delivery of medical care and would promote the public utility concept of medicine; therefore, be it,

RESOLVED, that we request that the North Carolina Delegates to the American Medical Association consider and evaluate each recommendation before voting on it.

VICE SPEAKER CARR: Is there any discussion regarding the amended resolution from the Reference Committee?

Hearing none, all those in favor of the amended resolution please say "aye"; opposed "no." It is passed.

Thank you, and thank you, Dr. Marshburn, and your committee.

DR. MARSHBURN: We recommend approval of the Reference Committee No. I report as amended.

VICE SPEAKER CARR: All those in favor say "aye"; opposed "no." The report is approved with our thanks to Dr. Marshburn and the other members of his Committee.

## REFERENCE COMMITTEE II

SPEAKER LYMBERIS: We will proceed with Reference Committee II. Will Chairman Kenneth Cosgrove as well as Dr. Shahane Taylor and Dr. Philip Howerton, come forth and give us the Reference Committee's recommendations?

DR. KENNETH E. COSGROVE [Chairman, Reference

Committee II]: Mr. Speaker and Honorable Delegates:

May I introduce my committee; Dr. Shahane Taylor from Greensboro, an ophthalmologist; and Dr. Philip Howerton from Morganton, a radiologist. This committee deliberated with knowledge because we had a very active Reference Committee meeting yesterday.

#### REPORT B

We would like to submit the following report and with regard *Report "B"* on the subject of the level of Medicaid payments from the Executive Council, the Reference Committee II recommends approval of this report.

**SPEAKER LYMBERIS:** Are there any questions regarding this report?

If not, all in favor of this report say "aye"; opposed "no." The report is adopted.

#### REPORT D

**DR. COSGROVE:** *Report "D"*: Subject: Opposition to HEW elimination of payments for abortions to the poor and indigent and to ask the legislature to make funds available for abortions to the poor and indigent.

The testimony presented in the Reference Committee hearing was predominantly in favor of Report "D." Reference Committee II therefore recommends approval of this report.

**SPEAKER LYMBERIS:** Does any member have a question regarding Report "D"?

If not, all in favor say "aye"; opposed "no." The report is adopted.

#### REPORT F

**DR. COSGROVE:** *Report "F"*: Subject: Increase in fee permitted to be charged by the Board of Medical Examiners for the issuance of a license. This was presented by the Executive Council. Reference Committee II recommends approval of this report.

**SPEAKER LYMBERIS:** Are there any questions regarding this report?

Hearing none, all in favor say "aye"; opposed "no." The report is adopted.

#### RESOLUTION 1 RESOLUTION 3 RESOLUTION 15

**DR. COSGROVE:** The following three resolutions were considered at one time.

Resolutions Nos. 1, 3 and 15: The balance of testimony at the Reference Committee hearing was in opposition to Resolutions Nos. 1 and 3 and supportive of Resolution No. 15 as amended. May I present as background information as we approached this decision, the report that was given by the Council on Legislation of the AMA and I would just like to quote from this because it states the problem we faced in deciding about these resolutions in good perspective.

I quote from the Council on Legislation report:

The message came through loud and clear that it was necessary and desirable for the AMA and others who had sponsored NHI bills in the Congress to continue their advocacy through such means. The consensus was clear that abandonment by the AMA of support of an NHI bill in the Congress would be extremely damaging to the maintenance of a role for the private sector.

Moreover, members of Congress have specifically counseled against any action of the Association withdrawing support for a national health insurance program, stating that to withdraw from the issue of national health insurance would amount to abandonment of its responsibilities to the Congress and to the public.

And, then, there was an additional part of this that I'm told by our AMA Delegates was probably written by Dr. Ed Beddingfield, and it certainly sounds like him and I quote:

To take a position, in effect, of "no position" on national health insurance would be interpreted by most people as abdication of the present and past position of the AMA in support of a proper national health insurance program. Similarly, a position of not supporting any bill for national health insurance would be undesirable as amounting to a decision not to participate in the development of any national health insurance program which may receive consideration in Congress.

It is important and necessary that the Association should take a position of involvement in the development of any national health insurance program and that the AMA should support a national health insurance program reflecting its views.

The Association's active influence could be effective in shaping a proper national health insurance program in the interests of the public, could play a major role in meeting the concerns of the medical profession, and could provide the best means of assuring financial access to health care for patients, while maintaining appropriate approaches to administration and financing through the private sector.

With this background, the Reference Committee II would like to recommend that Resolutions Nos. 1 and 3 not be approved.

**SPEAKER LYMBERIS:** Is there any discussion on Resolutions Nos. 1 and 3 and the recommendation of the Reference Committee?

**DR. JAMES E. DAVIS** [Past President; AMA Delegate of the Medical Society]: Point of order, Mr. Speaker! Would it not be more manageable and perhaps the intent of the Reference Committee if they submit their resolve as a substitute motion to be considered for adoption in lieu of Resolutions Nos. 1, 3 and 15 in which case we would not have to vote on each one of them individually?

Is that not the intent, Dr. Cosgrove, that you're recommending the adoption of the resolve which you call amended Resolution No. 15?

**DR. COSGROVE:** Yes, that was the original intent and I'll defer that question to the Speaker, please.

**SPEAKER LYMBERIS:** Have you read the resolve portion?

**DR. COSGROVE:** Not yet.

**SPEAKER LYMBERIS:** Then, your Reference Committee has the power to offer this as a consolidated substitute motion.

**DR. COSGROVE:** I will read the resolve and offer this as a substitute motion recommended by the Reference Committee II.

**RESOLVED**, that the North Carolina Medical Society reaffirms its support of the American Medical Association in sponsoring legislation on national health insurance which embodies the maintenance of a major role for the private sector and reaffirms its continued dedication to the free enterprise system.

**SPEAKER LYMBERIS:** This amended substitute resolution is now open for discussion. A substitute motion has been offered which replaces Resolutions Nos. 1, 3 and 15.

**DR. J. DOYLE MEDDERS** [Franklin County]: Mr. Speaker, Reference Committee Members: I'm Doyle Medders from Franklin County! I want to speak to Resolution No. 1 in opposition to the American Medical Association having a national health insurance bill and in opposition to all national health insurance.

I don't believe it would be worthwhile for me at this time



to go over all of the reasons that national health insurance is so disagreeable to the doctors of Franklin County. I believe that all of you will be in unison in realizing the grave threat to medical practice, to free enterprise, to the entire way of American life that national health insurance is, so I don't intend to go over that. The question really before us today is whether or not the American Medical Association should withdraw its national health insurance bill under consideration by Congress.

The primary arguments used by, well, let's say the bureaucratic thinking people, or the socialistic thinking people against the present medical system are that medical care today costs too much, and the other primary thing they're saying is that the poor people are not being cared for. Well, these arguments must have some truth since they're being taken so seriously by our Congress and by our American people.

I was glad to see the delegates vote a proposal for cost containment, this being a good indication that the doctors of North Carolina want to control costs. I think if we can really do that and really show that we're interested in getting the costs of all medicine and costs of the indigent patients, it would demonstrate to Congress and to the American people that we want to control costs.

I think that since they are taking it so seriously that all of us should ask ourselves if we are charging too much and what charges could be reduced, and of course on a voluntary basis, not on the basis of national health insurance. I think so, too, that each of us should ask himself if he has become callous and if he feels that he is not looking after the indigent patient. If so, I think he should try to give the indigent patient a break. He should try to give them good care and this should be done voluntarily and not by national health insurance legislation.

Well, what really is at stake here? National health insurance, and I'm of course including the AMA plan since it could be voted as law, as well as other plans, would cause a significant increase in the cost of medical care in this country.

The cost will be so great the taxpayer will be unable to pay the bill. We might mention that the most reasonable costs that have come up on these plans run anywhere from \$140 billion to \$500 billion. The total amount that the taxpayers of this country paid this past year was \$158 billion by the individual taxpayers and \$54 billion by corporate taxpayers.

The entire amount of tax paid by individuals and corporations will not equal the bill for National health insurance and the bill put up by the American Medical Association is going to be much more costly than the Kennedy Plan since it does not have the regulations built into it that is going to restrict people from getting service.

That is, the AMA plan is going to be tremendously more expensive. Medical care as all of us will agree, will deteriorate due to the droves of patients that will be trying to get seen, with doctors trying to see more patients than they can. Doctors working for the government, of course, are not going to be as interested in their work as private physicians.

Is the AMA plan really free enterprise? That was one of the big questions. The benefits offered by the American Medical Association plan are 365 days of hospitalization, free office visits, free emergency room care, free dental care, free institutional care.

This is certainly a socialized way of doing things.

In the AMA plan more than half of the finances is delegated to taxation, Medicaid patients, the unemployed, any family making under \$6,000, plus the cost of everyone who makes a salary of less than \$11,000. Part of the cost is small business. All of the costs over \$2,000 to everyone as far as

taxation. Surely, with more than half of the cost of the plan being borne by taxpayers, this is a socialistic plan.

Another question brought up is, is socialized medicine really necessary? No!

The complaints of the Congress and the American people can easily be corrected by physicians if they were really concerned about costs and patient care. We need to get the Comprehensive Health Insurance Act of 1977 off the books of Congress. This bill is handicapping our legislators. How can they convince Congress national health insurance is not necessary when doctors have proposed this bill? This bill is helping socialistic congressmen who can point to the bill and say even doctors want national health insurance.

This bill confuses the American people making them think that doctors want national health insurance. There's always the possibility that this bill might be enacted into law and then what a mess we'd be in. The truth of this matter is that the proponents' argument toward medical care at the present time has some element of truth.

It's the truth also that socialism and free enterprise is more the question here than medical care. I think, since more and better medical care is offered at the present time than in any other country. And, I think Dr. Beddingfield would see the weakness in doctors recommending this program and I think he would have the courage to withdraw this plan once he had seen the developments of the present day.

DR. BAILEY: I'm Lloyd Bailey, Edgecombe-Nash Society. Mr. Speaker, Fellow Delegates and Guests: I am speaking for Resolution No. 3 which proposes to have the AMA withdraw its bill for national health service.

We have been coming here year after year debating the same subject. Let's stop and look at the record! Have we won? No, we have not.

We are fighting a defensive battle and we continue losing one step at a time and I think all of us are aware of this. We have elected to defend medicine in an atmosphere which is foreign to physicians — the political negotiating table; an area in which we usually have very little expertise.

Our adversaries at the political negotiating table are professional politicians whose very survival depends upon taking over the medical profession. Politics is said to be the art of the possible, or the art of compromise.

Ladies and gentlemen, we have nothing to compromise! Any slightest compromise on our part is a defeat for medicine, or a defeat for us and a victory for those who wish to abolish the free private practice of medicine.

If you were Wilbur Hobby or Joseph Califano where would you choose to do battle with the AMA? Naturally, at the negotiating table, the political arena, where the odds are in your favor, wouldn't you? I think I would.

It is generally agreed that we have the highest standards and the best system of delivery of medical care in the world, so why don't we have the fortitude to defend it? Why? I'll tell you why! It's because we have given up!

It's probably safe to say that most of us in this room are resigned to the fact that socialized medicine will some day be imposed upon us and our best efforts are expended simply to delay it. Why not defeat it?

It is also probably safe to say that we would already have socialized medicine in this country if the AMA had not stood firmly against it and for us. We are told that we are bargaining for national health insurance, not socialized medicine. Let's not delude ourselves — a rose is still a rose by any other name!

When the government planners and regulators get through with it, it will be socialized medicine. They operate by using the strategy of patient gradualism. Why did the AMA change its position? I'm not in a position to say, but it probably is

because the planners have whittled away at and eroded the AMA defenses over the years.

And, now the AMA is advocating the very thing that it formerly so honorably opposed and we are told that we must make the best deal that we can. We have lost battles but the war isn't over, and it won't be over until the last vote is counted in Congress.

After losing battle after battle, it's usually a good idea to stop and reassess your positions and change the strategy if indicated. This is where we are today.

Let's change our strategy and change the arena to our own home court where the odds are more favorable. We can change our appeal to our patients, the constituents who elect the representatives who will finally decide the issue. It worked in the past. The vast majority of Americans is satisfied with medical care and the polls reflect this, with the medical care they're receiving now.

If public opinion can be aroused, the bureaucrats will be defeated for the climate in this country today isn't exactly favorable to bureaucrats and we all know this. This is a positive approach and it can work.

The Right to Work Committee defeated on site picketing by using this approach when the purveyors of gloom and doom stated that it couldn't be done.

Two weeks ago, I attended a meeting of the Association of American Physicians and Surgeons in Washington, as a delegate from North Carolina. It was one of the most refreshing, battery charging sessions and experience that I've ever had.

AAPS, for those of you who may not be familiar with it, is a national medical organization, some 20,000 strong which was formed simply to help preserve the free enterprise practice of medicine and medical ethics. There is no sense of despair there. We are on the offensive and our approach is very positive.

We are enlisting the American people in this fight. Within the past six to eight weeks, a citizens committee was formed to oppose socialized medicine and it was patterned after the "Right to Work Committee." This is just being started so we don't know the results yet. Imagine the impact if the resources of the AMA were also put into this battle in a similar manner. It might surprise and encourage all of us.

We are not alone! The Ohio House of Delegates just recently reversed its position and now is advocating the AMA withdraw this bill and the Ohio House of Delegates, among others, is opposed to any form of national health insurance and socialized medicine.

Fellow Delegates, let's get into this battle in the old American way and pursue it to victory. We can do it!

How many of you are willing to stand up for what we know is right?

DR. A. J. CRUTCHFIELD [Forsyth County]: Jack Crutchfield of Forsyth! I thought I would just read a few names familiar to most of us:

Harvey Estes; David Welton; John Glasson; Louis Shaffner; Jim Davis; Frank Reynolds, and I could read some others. If we decide that we don't want to risk being stained by going where these deliberations take place, then it means we don't have an opportunity to put these people on exhibit, as our warm bodies will help warm some of the cool bodies in the country up and this would be a tragic mistake.

So, we know from our experience with Medicare legislation, those of us who are old and gray, that this is not prudent. We would, of course, prefer that things were simple, that we don't have to do this, but there are very substantial credentials among our prophets who say that a national health insurance system will be, it's imminent.

We would be better advised to have people like this be

there in all these deliberations, to the end that we get something that resembles this that would come out of these deliberations. That's what the American Medical Association has consistently urged, that any national health insurance should build on existing private insurance and not be operated as a government service, but should be financed by private payments by those able to pay and from general taxes for low income groups.

It should utilize our pluralistic health care system. It should be comprehensive. It should have minimal federal involvement and should not be financed by a payroll tax, no administered under Social Security and that's pretty close to what most of us believe in.

Rather than sit here and at home and hope that it will come out so that the public will be well served, Congress would be well served, we will be well served, it's better that our best people be there and do what is possible to make what comes out of it the very best for everybody.

DR. DAVID G. WELTON: (AMA Delegate for North Carolina) Mr. Speaker, and Members of the House: I'm speaking for your Delegation to the AMA, in behalf of the substitute resolution offered by the Reference Committee. I shall not go into all the details. It would occupy several hours to do this.

The subject has been debated by this House before. We have been involved in the debate of this subject, and in the discussions of it in the Reference Committees of the AMA and the House of the AMA for several years. I will give you a quick summary of why the AMA is sponsoring a bill for comprehensive health insurance which it has done since 1970.

First of all, the public perceives a need for this and all the polls show that.

Second, the labor movement pressure on congress for it is very, very intense and if you have followed the recent papers, you'll notice that the White House announced and directed Mr. Califano to put a bill on the floor sometime this year, whereas they were planning to wait until next year, this was done at the insistence of the labor people.

Third, we must have a bill in the hopper if our views are to be considered in whatever congress deliberates and comes up with and nobody believes that any bill that has been submitted is going to come through there unchanged.

Four, withdrawing support of the AMA sponsored bill, at this point, would have very serious consequences for all of us and for our patients.

It would leave conservative congressmen with no place to go. There are over 52 of them who have sponsored the AMA bill. Furthermore, it would seriously impair the credibility of the AMA's interest in any other health bill pending before congress.

We have had the privilege, until last fall, of having the leadership and the wisdom of Ed Beddingfield and you have heard several quotations from him. Now, Ed believed very strongly in this bill. Among other things he stated that the AMA sponsorship of such a bill is an important entree to the debate and that an AMA pull back from the legislation as now sponsored for almost a decade would cause the Association to lose credibility on all issues.

Now, your delegation has studied this for a number of years and I'm prepared to tell you, on their behalf now, that we think we should continue our support of the bill sponsored by the AMA.

In conclusion, we submit to you that this solution, we think, comes the closest to preserving the private practice of medicine, the private health insurance industry and the principles that this House has embodied.

SPEAKER LYMBERIS: Is there any further discussion



on these three motions?

All in favor of the question will raise their hands! This is a clear majority, so there can be no further discussion.

The Chair accepted the Reference Committee resolve as a substitute motion to be considered in lieu of Resolutions Nos. 1, 3 and 15—

So, the vote is on whether or not you're going to accept or reject the substitute motion as submitted by the Reference Committee.

You are now voting on the following:

**RESOLVED**, that the North Carolina Medical Society reaffirms its support of the American Medical Association in sponsoring legislation on national health insurance which embodies the maintenance of a major role for the private sector and reaffirms its continued dedication to the free enterprise system.

This is the question. The question has been called. All in favor will raise their hands!

Opposed, raise your hands!

The substitute resolution is adopted in lieu of Resolutions 1, 3, and 15.

### RESOLUTION 7

**DR. COSGROVE:** I will now go on to *Resolution No. 7* presented by the Pitt County Medical Society.

**Resolution No. 7:** Subject: Support the recommendation of the OMB (Federal Office of Management and Budget) that funds for PSRO be dropped.

After considerable discussion in the Reference Committee hearing, it was concluded that this resolution was inappropriate since the PSRO program had been fully funded. There was also a strong feeling by many present that PSRO activity was presently an effective, physician controlled program which had potential for cost containment as well as improved quality of medical care. Reference Committee II, therefore, recommends Resolution No. 7 be filed.

**SPEAKER LYMBERIS:** Is there any discussion on the motion of the Reference Committee?

If not, all in favor of this motion please say "aye"; opposed "no." The resolution is filed.

### RESOLUTION 10

**DR. COSGROVE:** *Resolution No. 10*, presented by the Catawba Medical Society. Subject: Support of Position Paper Regarding Primary Care in County Health Departments.

Reference Committee II submits the following substitute resolution:

**RESOLVED**, that the House of Delegates approves this position paper but also recognizes that there exists a medical care need in underserved areas; that the Department of Human Resources is responsive to this need and that some system of care must be made available in such areas. We, therefore, support the Governor's invitation to participate in a task force study to identify the most efficient way that these needs may be met and suggest that the President of the North Carolina Medical Society make available to the Governor selected physicians to work with the task force. Reference Committee II recommends approval of this substitute resolution.

**DR. JOHN A. HENDERSON [Buncombe County]:** I'm John Henderson from Buncombe County! It is my impression that funds are already being made available to county health departments and I would like to move for an addition to this resolution to read as follows:

Further, be it, **RESOLVED**, that funding of county health departments for primary care be deferred until after the task force makes its recommendations.

**SPEAKER LYMBERIS:** First, is there a second to this amendment? There is a second. Is there any discussion of this amendment?

**DR. GLASSON:** I'd just like to ask the question — did he say further funding, or funding?

**SPEAKER LYMBERIS:** Will you please restate that portion, Doctor?

**DR. HENDERSON:** I said funding, but if there is already funding going on, further funding would be appropriate. I may be in error on whether funding has already been started, so I believe it would be better to say that "funding of the county health departments for primary care be deferred."

**SPEAKER LYMBERIS:** You have the privilege of inserting this change if you wish to.

**DR. HENDERSON:** I would not wish to.

**DR. JOHN L. MCCAIN [Wilson County]:** I'd like to speak against the proposed amendment in that as it reads at the present time, this would put us in a bad position in that this goes against any funding.

This would mean that the patients who are supposed to come to the office tomorrow, if the Department of Human Resources went by what this resolution says, they could not come to the office tomorrow if the funds were necessary for continued service, so I speak against the amendment.

**SPEAKER LYMBERIS:** Is there any further discussion? Then, we are voting on the amendment.

All in favor of the amendment say "aye"; opposed "no." Let us have a show of hands and will the Tellers make a count, please?

All in favor will raise their hands. I think the amendment has received the necessary majority.

So, now, we will vote on the amended substitute resolution.

Is there any discussion of the amended substitute resolution?

If not, all in favor of the motion as amended will raise your hands. This constitutes a majority and the substitute resolution as amended is adopted.

### RESOLUTION 11

**DR. COSGROVE:** Yes, we'll go on to *Resolution No. 11* which was presented by the Catawba County Medical Society.

**Resolution No. 11:** Subject: Opposition to the proposed North Carolina Health Planning and Certificate of Need Law for 1978 General Assembly.

This is rather a complicated situation and I would just like to make a few background comments before I offer the substitute resolution. As you all know, the courts have turned down our joint attack with the State on the constitutionality of the Health Planning Act. Therefore, our State must comply with federal requirements for Certificate of Need, or forfeit \$50 to \$60 million.

This resolution that we are proposing intends that we do not oppose the State from enacting legislation which will comply with federal law, or what we can reasonably expect the federal law to be and I refer to the Rogers Amendment which is now before Congress.

A constitutional amendment must be passed next fall to accommodate this type of legislation and what form that will take is just a big question mark. Possibly, such a constitutional amendment would authorize legislation which might affect our practices in the future.

In essence, in this situation, we are between a rock and a large stone. Our only alternative is to oppose any Certificate of Need legislation and pay the penalty, or to totally agree with the Certificate of Need concept and accept Certificate of Need requirements for all or most of our office needs.

In light of this discussion, I would like to present a substitute resolution as follows:

The ability of a licensed physician practicing in North Carolina to effectively and intelligently diagnose and treat illness in his patients depends on his freedom to exercise his skill and judgment.

The exercise of that skill and judgment often involves the use of devices and equipment to make such diagnosis and treatment possible.

Now, therefore, be it,

**RESOLVED**, that the North Carolina Medical Society opposes the enactment of any law at any level of government that would restrict the right of a physician to make proper use of devices or equipment to care for patients on an outpatient basis.

Reference Committee II recommends approval of this substitute resolution.

**SPEAKER LYMBERIS**: Is there any discussion on the substitute resolution?

If not, in favor of the substitute resolution will say "aye"; opposed "no." The substitute resolution is adopted.

### RESOLUTION 12

*Resolution No. 12*: Subject: Reporting drug abuse to local health departments and this is presented by the Cumberland County Medical Society.

This recommendation was considered to be impractical by physicians as well as the representatives from the Division of Health Services. The testimony against this resolution was overwhelming. Reference Committee II recommends that Resolution No. 12 not be approved.

**SPEAKER LYMBERIS**: You've heard the recommendation. Is there any discussion on this resolution or the recommendation?

If not, those who favor the Resolution, which your Reference Committee opposes, will raise their right hands. Now, again, to vote "aye" is to vote against the recommendation of the committee. I just want that understood.

So, we are voting for the resolution as stated. All in favor say "aye"; all opposed "no." The recommendation of the Reference Committee is upheld.

### RESOLUTION 13

**DR. COSGROVE**: *Resolution No. 13*: Subject: Proposed expansion of treatments of cancer sponsored under the State Cancer Diagnosis and Treatment Program, which is presented by the Forsyth-Stokes-Davie County Medical Society.

The balance of testimony at the Reference Committee hearing was in favor of opposing this resolution. Present funding of the Cancer Diagnosis and Treatment Program is inadequate and until such additional funding is appropriated, further expansion of this program is not feasible.

Therefore, Reference Committee II recommends that Resolution No. 13 not be approved.

**DR. BYRNES**: Tom Byrnes of Davidson County! Since we all favor expansion of the cancer program, a negative vote may sound like we don't and I wondered if it might not be more appropriate since funds aren't available, to file this resolution instead of disapproving it, and I so move.

**SPEAKER LYMBERIS**: Is there a second to the motion to file?

**DR. CRUTCHFIELD**: Second.

**SPEAKER LYMBERIS**: It is seconded. We will then have to vote on the substitute motion which is to file. All those in favor say "aye"; opposed "no." The resolution is filed.

### RESOLUTION 14

**DR. COSGROVE**: *Resolution No. 14*: Subject: Non-confidentiality of information on current certificate of live birth, presented by the Craven-Pamlico-Jones County Medical Society.

Reference Committee II submits the following substitute resolution:

**RESOLVED**, that the North Carolina Medical Society recommends the enactment of appropriate legislation to protect the confidentiality of the information contained in the certificate of live birth, as follows:

- a) educational status of both parents
- b) race or color of both parents
- c) number of pregnancies
- d) marital status of mother
- e) complications of pregnancies
- f) complications of labor and delivery
- g) congenital malformations or abnormalities of child.

Reference Committee II recommends approval of this substitute resolution.

**SPEAKER LYMBERIS**: You've heard the recommendation for approval of this substitute resolution.

Is there any discussion? If not, all those in favor say "aye"; opposed "no." The substitute resolution is approved.

**DR. COSGROVE**: Mr. Speaker, that completes our report of Reference Committee II and recommends approval of this report as it has been amended.

**SPEAKER LYMBERIS**: You've heard the recommendations of the Reference Committee.

All in favor say "aye"; opposed "no."

Your recommendation is accepted with great thanks.

At this time I would like to take the personal privilege of this Speaker's Chair to introduce a new member of this Society, my son, Dr. Lymberis!

[Whereupon Dr. Marvin E. Lymberis stood up to be recognized.] I sincerely hope that this body can encourage more house officers and students to join with us in our deliberations and activities.

I'd like now to ask Dr. Jim Davis, who is President of our Medical Mutual Insurance Company, to give this House a report on the status of that company.

### REPORT ON MEDICAL LIABILITY MUTUAL INSURANCE COMPANY OF N.C.

**DR. JAMES E. DAVIS** [President, Medical Liability Mutual Insurance Company of North Carolina]: Thank you, Mr. Speaker.

The Medical Liability Mutual Insurance Company of North Carolina is, of course, an offspring of the North Carolina Medical Society, and, as a dutiful child, we appreciate the opportunity of bringing you our report card, hopefully, for your approval and signature.

During the last twelve months, your company which is an infant of only two-and-a-half years, is very interested in growth. It has grown by adding more than one hundred new physician accounts per month.

A hundred doctors who have not been with us before have joined us each of the last twelve months, which means that currently we are insuring about 3300 physicians in North Carolina.

Other accomplishments during the year include the fact that the rate for "claims made" insurance has been reduced, this time by 22 per cent which means they have been reduced a total of 50 per cent in the two-and-a-half year life of your company.

We have paid a six per cent interest payment to those of



you who hold our capital bonds for the year 1977. Each of you did receive a check in early January.

We are now offering the \$2 million/\$2 million coverage for those of you who want added coverage, or higher coverage than was previously available.

We're very proud of the fact that we are now covering the clinical staff at East Carolina University and all of their 37 physicians are now doing business with your company.

We have now started an agency operation which those of you who had a chance to visit our booth in the lobby know that this means that we are now prepared to handle all lines of insurance for you.

If you haven't had an opportunity, I hope you will stop by our booth, pick up a card that you might write back into the company for any insurance information that you want.

During the last year, we have achieved greater financial stability in the fact that we now have \$4.75 million in investments that are returning approximately eight per cent.

Our reserves are \$2.7 million and held against any claims which may be forthcoming in future years and as you realize we are liable only for the first \$100,000 of a claim. Our reinsurance will be liable for other claims, so we think this is quite good reserves.

So, in summary, then, we feel that your company does continue to operate well. We are optimistic about the future.

We think we are moving ever closer to our goal of stabilizing a competitive market in North Carolina to avoid the monopoly that existed before and, secondly, to continue to reduce rates.

I can say, whether you're insured with us or not, and I hope you are, but if you are not, this company is continuing to lower your rates because the other company in North Carolina continues to meet our lower rates and several institutions in the state have benefited from the fact that we have both had to compete and bid on large contracts which means in a couple of instances \$50,000 and \$100,000 have been saved in insurance coverage.

Thank you very much.

#### REFERENCE COMMITTEE ON PRESIDENT'S ADDRESSES

SPEAKER LYMBERIS: Dr. Philip Nelson, Chairman of Reference Committee on Presidential Addresses, will give their report now.

DR. PHILIP G. NELSON [Chairman, Committee on Presidential Addresses]: Mr. Speaker, Fellow Delegates: The Committee on Presidential Addresses consisted of Dr. Bruce Blackmon, who is here, Dr. Edward Eadie and myself. Because of family illness, it became necessary for Dr. Eadie to leave Pinehurst earlier this morning. Dr. Blackmon and I were joined by Dr. Robert Poston in our deliberations.

The committee wishes to express to Dr. Estes its deep appreciation for his positive leadership during the past year. We feel it has been reflected in his two addresses.

We feel that Dr. Estes has brought the medical teaching profession closer to the general medical practitioners. We are mindful of the fact that years ago there were many academic physicians who were not very active in our Society.

In his first speech, Dr. Estes gave a review of his year in office and a picture of the battles, the objectives and the accomplishments of his administration. You will recall that he reminded us that medicine is still an art and as physicians we need to be available to our patients 24 hours a day, and that in our relationship to society we need to stress the importance and practicality of the word "ethic."

He also gave us a challenge to approach today's and

tomorrow's medical problems in sound and perhaps innovative ways.

Our President urged us to become politically active and to be involved in today's world. He has also urged us to support together within the framework of the law, but to strive as much as possible for free enterprise in our profession; as much free enterprise as is consistent with the welfare of our patients.

He has urged us to consider new methods of providing quality medical care for our patients.

In summary, it seems to us that Dr. Estes in his administration of the North Carolina Medical Society for the past year is a direct confrontation to the recent negative comments about American medicine from the President of the United States.

Harvey Estes is well aware of the social, political and economic as well as scientific forces that are today affecting medicine.

His concern has not been just with us as physicians but more importantly, his concern has been with the quality of medical care, the continuing of medical care and the feasibility of medical care for the patients and the people of our State. Thank you.

SPEAKER LYMBERIS: Do I hear a motion that this report be accepted?

[Whereupon the motion was made and seconded from the floor.]

All in favor say "aye"; opposed "no." It is accepted.

SPEAKER LYMBERIS: Is there any New Business to come before this House?

DR. TILGHMAN HERRING [Wilson County]: I'm Dr. Herring from Wilson! I would like to offer a piece of New Business in the form of a proposed position statement on certain remarks made by Mr. Carter yesterday. We propose that this House adopt a position on this.

SPEAKER LYMBERIS: And, you offer this in the form of a motion?

DR. HERRING: Yes, sir, or however I should offer it!

SPEAKER LYMBERIS: This House may accept a motion on New Business. It cannot accept a resolution except by suspension of the rules and a two-thirds majority of the House. I should feel a little bit safer, without consulting with another parliamentarian, if we would ask for suspension of the rules to receive this.

DR. HERRING: All right, then I ask for suspension of the rules.

SPEAKER LYMBERIS: Will the House agree to suspension of the rules to receive a new resolution from Dr. Herring?

All in favor say "aye"; opposed "no." You have that majority.

DR. HERRING: Most of the members of the House have probably seen in the paper headlines about Mr. Carter's remarks yesterday. I will read from the *Raleigh News and Observer*.

Mr. Carter is quoted as saying:

Doctors care very seriously about their patients, but you have doctors organized into the American Medical Association and they're interested in protecting the interests not of patients but of doctors.

And, they've been the major obstacle to the progress in our country to having a better health care system in years gone by. End of quote of Mr. Carter!

It seems to me that the House being in session should perhaps take a position on such a statement by our President and I will read this resolution:

In opposition to the remarks by President Jimmy Carter

yesterday, the American Medical Association has been the *best* initiator of realistic progress in our country for the development of a better health care system. No other organization has had so significant and favorable influence on the changes which have resulted in a health care system in America which is the envy of the world.

The democratic organizational structure of the AMA provides access to the voice of the local personal physician which assures that the individual patient care provided is personal, humanistic, appropriate and current.

The grass roots orientation of the AMA has allowed national planning and programs to be responsive to local health needs and problems as they arise including programs in medical care accessibility, health care for the underserved, quality of care assurance, new knowledge application, continued practitioner competence, cost containment, medical manpower production.

Because of the experience and concern for the medical care of the people, we believe the health programs of the nation can best be served by more rather than less input from the AMA provided with less interference from the federal government.

**SPEAKER LYMBERIS:** You have heard this resolution. Do I hear a second?

[Whereupon it was severally seconded from the floor.] All in favor say "aye"; all opposed "no."

The resolution is carried by acclamation.

#### REMARKS BY AMA TRUSTEE

Gentlemen, it is now a distinct pleasure to ask Dr. David Welton to bring forth a very distinguished visitor, Dr. Hoyt Gardner, who is a trustee of the American Medical Association, who is a candidate for President-elect of the American Medical Association. Dr. Welton, will you please escort Dr. Gardner to the podium?

[Dr. Gardner was duly accorded a standing ovation.]

**DR. HOYT D. GARDNER** [Member of the Board of Trustees, American Medical Association]: Mr. President, Mr. Speaker, Members of the Leadership at the Head Table, Colleagues, Brothers and Sisters:

It's a great pleasure to bring you greetings from your Association, the American Medical Association. It's indeed an extraordinary pleasure to bring you some greetings that are somewhat unusual I'm told the last two or three years; that is, we are solvent! We're putting money in reserves.

We're in deep entanglements legally with the federal government because, in your name, in behalf of all of us, we have reached the point that not only is legislative commitment and embattlement our intent, but we also intend to embroil them legally when they have acted in what we feel is an unconstitutional manner.

I know that you're aware of North Carolina's suit with us and the fact that we did not achieve the success with it that we wished, but it does not mean we will not try again, nor that we've entirely reconciled ourselves that the supreme court is the epitomy of final judgment.

As a matter of fact, I think I can use an analogy as I speak to you today as to how we feel about the federal government and what it's trying to do in health care.

After all, remember when any government gets the responsibility for health care, it's no longer a political priority, it becomes a budgetary hardship and as a consequence, there's limited access, there is suppression of opportunity between doctor and patient, there is technological inhibitions because of budgetary handicaps from government, and, finally, there is an equality which is less than normal when the opportunity of people to do without suppression have an opportunity to do for themselves.

Let me speak of an analogy of what I'm talking about.

It's like the man and his wife who decided to redecorate their home and the wife, of course, came up with the idea which is the usual way and he went over the plans with her and decided it was really a grand idea and he agreed with her so they called in a decorator. The decorator presented his ideas and the husband agreed that it was marvelous and gave him an unlimited budget.

Two weeks later he was talking to a colleague and he said, "You know, I went over all these plans, they were wonderful and I agreed with my wife on the decorator and I gave him an unlimited budget and do you know the so-and-so has already exceeded it!"

Let me point out to you where they have already exceeded. First of all, all federal programs to date in the health care arena have not yet been fully funded and I speak specifically to Medicare and Medicaid; I speak specifically to the Indians; I speak specifically to the Veterans; I speak specifically to any bureaucracy of medicine that the federal government has impounded upon the people that they have fully funded it realistically in proportion to today's economy.

They have not argued with this, any time that statement has been made because you know the profession itself has carried anywhere from ten per cent to over half of the Medicaid physician fee responsibilities, not the federal government.

I could go on and on with other numerous examples but anyway that's what I bring you, greetings from on high from your organization, the American Medical Association.

I would only speak to two other points that we're now striving toward.

Your Association, at the national level, in the last five years has changed considerably. Staff has been overhauled. There are now 900 people instead of 1100 in 535 North Dearborn.

Your 26 publications and by the way, this profession is the most publicized profession and it's the most communicated with profession in the world. Our 26 publications, with the exception of two, are now on a paying basis. Before, there were 23 of them that were not.

I can say to you that our membership while at grievous low levels, is growing larger with our medical student division and with the interns and physicians, resident physicians section.

I can speak to you in other ways. Today, and in the last two or three years, you have not heard it said that staff is running the American Medical Association. It is not! The Board of Trustees is acting as custodians for the House of Delegates and the House of Delegates is running the American Medical Association today.

The policies that they establish are adhered to completely. That is most healthy because it speaks of the democracy of our profession and it speaks of the democracy that occurs at state meetings such as this one. You make the selection of the leadership that you feel is dependable, that you feel is intelligent, that you feel is going to speak your mind and you send them to the national meetings and at those national meetings out of the debate and the discussions, and all the broad work of men's minds comes the policies of the American Medical Association.

This current Board of Trustees is completely devoted to carrying out those policies exactly as they are voted by the House and they have been.

So, I speak to you at a moment of pleasure of pride, some accomplishment and we're just starting, but today the American Medical Association, as it is exemplified with the Board of Trustees, and by the staff, speak for you.

Now, let me finish with one final thing.



We have a commitment coming up that is a complete commitment. It's a commitment of unity!

Now, the national leadership and the state leadership, as you know, they're all speaking to the angels: Where we are in default and where it must be corrected and where we are drawing our attention in the next two or three years, is a commitment to the grass roots.

It's no longer possible for an individual physician to feel that he does not carry some of this responsibility, that he is not also responsible.

Why did this come about?

We have polled the population intensely, both within the profession and without the profession across this country for the last three years and we find the biggest disagreement today is the inter-communication between the physician and his patient, a startling revelation because we have always said and adhered to the idea that our strengths laid in the physician/patient relationship, but today polling across the country, by the best people that we can find, we are finding there's some breakdown in that mechanism.

People are saying they're waiting too long, they have functional disagreements with being able to talk to their doctor in death.

They have no disagreement with your technology, your diagnostic acumen and despite what they say about malpractice problems, they are not considered a severe problem by the population outside the profession. They feel you are extraordinarily competent.

They feel you are very difficult to communicate with. We feel you are difficult to communicate with when it gets down to the doctor in the grass roots because over and over and over again it's said by the doctor at those levels, as you know so well yourselves in positions of leadership as delegates and representatives, they say, "What's North Carolina Medical Society done for me lately?" "What's the American Medical Association done for me lately?"

And, yet, we are the most communicated with profession not only in the world today, but in history.

So there is a breakdown that the fellows at home are not receiving. There's an enormous amount being sent out.

So, we're going to come to work in the states, with your help, and really try to carry the message back down to the fellows, not only the fact that they hear, but they react and that they understand and that our positions of strength that we feel based on the House of Delegates actions to react to government, to react to need; will be understood and not necessarily be disagreed with because if strategy is clear, if positions of strength are obvious to people at high leadership there's something wrong when the fellows at home don't understand it when there's a deluge of mail going out all the time telling them this is what's going on, these are the positions, this is why and they don't know about it.

It feels now to be the responsibility of you, the State Association or the American Medical Association if the fellows in the trenches are going to become more alert, more responsive, more reactive and then, as a consequence, the complete unity that we've been looking for will be ours and the strengths that we have and the wisdom that we all share in our training, and our opportunities will not be lost because we will have fragmentation of communication.

It's a great pleasure to be with you. I can't miss this opportunity to speak about a colleague that was close to all of us in national leadership, Ed Beddingfield.

Ed's time and mine were corollary. We were compatriots and contemporaries. You always think of the pleasures of the association with an unusual and gifted person such as he and the loss, of course, is most grievous, but after the solace of time, you do look back to the many pleasures.

I think of it in three ways and one of them I heard last night when it was said to me, as it happens so often with wives who have husbands who get involved in these commitments, that one afternoon one of the girls came across Lorraine sitting outside the meeting and she said, "Oh, I bet you're waiting on Ed?" and she said, "Yes, I am!"

She said, "Gosh, I bet you get tired of that because you have to do it so often!"

And, she said, "Oh, no, I don't. He's worth waiting for!"

I thought that epitomized it so well. He was indeed a man worth waiting for.

And, I think of another way and we have a term back in Kentucky — as a matter of fact, we're going to have another historical event in about forty-five minutes in Kentucky!

But, there is a characterization at home when you want to speak in the highest terms — now, this may sound not so high to you, but let me tell you in the Bluegrass, this is the highest terms you can speak of somebody — when you want to speak in the best way about a person, you say, "Now, there's a real thoroughbred!"

It can be said that Ed Beddingfield was a real thoroughbred.

And, lastly, I had an experience once again of someone being spoken of in the highest terms by a gentleman of very low stature, that made a living out of carpentry and mowing lawns, but he did this for people at all levels and he characterized them in various and sundry ways. Some of them would not be appropriate for a podium and a very small number of them would not be appropriate for a one-on-one communication.

But, he had a term for people who had treated him, the lowest type of person in the economic and social scale, he said and gave this accolade and praise to somebody, it was truly a commendation, when he said, "That person is a prince!"

I say to you that we walked with a prince; we've had a colleague who was a thoroughbred and he was indeed worth waiting for.

I thank you for this opportunity and I look forward to visiting with you again tomorrow.

God speed; best wishes!

[Whereupon the entire assemblage then accorded Dr. Gardner a standing ovation.]

**SPEAKER LYMBERIS:** Thank you, Dr. Gardner.

Mr. Hilliard has some short announcements he would like to make to this House.

**MR. WILLIAM N. HILLIARD** [Executive Director of the Medical Society]: Very briefly, I just wanted to make you aware that the registration as of this moment is only nine short of equalling last year's and, undoubtedly, with registration open again tomorrow, we will exceed last year's registration.

As for membership in the North Carolina Medical Society, as of Tuesday of this week, we were only 36 short of dues paying members equalling the membership as of December 31, 1977 so during the month of May we expect to exceed the 1977 dues paying membership.

**SPEAKER LYMBERIS:** Before declaring this House adjourned, I must thank the Vice Speaker for his inestimable help and even more than any other group, the marvelous staff that this Society has to transact its business.

I'm sure that Dr. Estes and the Vice Presidents, Speaker and Vice Speaker could not possibly do their jobs as competently as they have been able, I think, to perform them without this marvelous assistance.

Before asking you for adjournment, I would like for you to give our Medical Society staff a rousing vote of thanks.

DR. DAVIS: Mr. Speaker, point of personal privilege, please!

SPEAKER LYMBERIS: I recognize Dr. Davis!

DR. DAVIS: May I please request the members of this House of Delegates join me in expressing our appreciation to our Speakers for their very efficient, fair and equitable management of our sessions today and on Thursday, and to congratulate them on a job very well done.

SPEAKER LYMBERIS: Thank you, Ladies and Gentlemen, Delegates.

I now declare this House adjourned, sine die.

[Whereupon the meeting adjourned at four-fifteen o'clock.]

**SPECIAL SESSION**  
**FRIDAY MORNING — May 5, 1978**  
**8:30 a.m.**

**To hear the Governor of North Carolina**  
**The Honorable James B. Hunt, Jr.**

A Special Session of the North Carolina Medical Society convened at eight-thirty o'clock in the Cardinal Ballroom of the Pinehurst Hotel, Pinehurst, North Carolina. Dr. E. Harvey Estes, Jr., President of the Medical Society, presiding.

PRESIDENT E. HARVEY ESTES, JR.: Ladies and Gentlemen: If there is any person in this State who needs no introduction for an audience of this sort, it's our next guest.

Governor Hunt, we're extremely pleased to have you with us this morning and we look forward to hearing what you have to say about these issues of so much importance to us all. Thank you for being here!

[Whereupon the entire assemblage then accorded Governor Hunt a standing ovation.]

HONORABLE JAMES B. HUNT, JR. [Governor, State of North Carolina]: Thank you, very much, Mr. President.

My good friend, Lorraine Beddingfield, whom I haven't seen yet this morning, but I think she's here; Dr. Sarah Morrow, our wonderful Secretary of Human Resources; my friend, Dr. David Bruton, who chairs our State Board of Education; Dr. Archie Johnson; Dr. Jim Davis, with whom I've worked so closely in a year when we made so many critical decisions that affected medicine in this State; Dr. D. E. Ward, who is your President-elect with whom I look forward to working with next year; Dr. John Dees, who so kindly invited me to speak to your North Carolina MEDPAC banquet this evening and I had a previous commitment that prevented that and I appreciate your letting me come this morning.

But, I do want to say, as I've said to you all on many occasions before, how critically important it is, not only for your profession, but in terms of this State being what it ought to be in this country, being the country we want, that you be actively involved in political affairs.

That's an opportunity we have in a democracy and we need that today more than ever before.

Members of the Medical Auxiliary who are here this morning who I have a special place in my heart for, in part because of your active pushing of the Health Education Program in our public schools and I want you to keep working on it because I think we're getting very close to that.

I recall very closely our association in 1976 when we worked hard, of course, on the malpractice matter and I want to commend you, Dr. Estes, for the new company that you've established and I understand it's working very well.

In fact, I'm told it's done so good that now the lawyers in North Carolina have one! I understand that you call yours

the "Bed Pan Company" and the lawyers call theirs the "Spittoon Company"!

Our association is one that means a great deal personally to me and your work with the public leaders of this state means an awful lot to North Carolina.

I recall the wonderful Conference on Children that we had a couple of years ago that you helped motivate and sponsor, which has had so much effect in terms of what we've been doing.

Just last year, the wonderful Conference on Aging and not a single day goes by that I don't hear from somewhere across North Carolina the results of that conference and what's happening in individual counties; what we're doing at the state level to try to provide greater opportunities for our elderly people.

I'm proud that Dan Gottovi is going to be representing you and North Carolina in the planning for the White House Conference on Families.

I would say to all of you that I would hope after — either before or after — that White House Conference that we would have conferences throughout this state on families.

There are some statistics in the paper this morning that make you realize that we absolutely must have more effective families if we're going to have better health and a better state.

I also want to say to you that I'm very proud of this Society and I'm very proud of the physicians in North Carolina.

I don't think I ever go to a Governors' Conference or some of these national conferences that get into questions of human beings and human resources that I don't have a chance to point out where we are so far ahead of so many of the rest of the states in this country and that has come about in large measure, and probably primarily, because of the public spirited attitude of this Society, and you as individual members, and the progressive nature of this Society. I want you to know that I appreciate that.

I recall, for example, being out in the State of Iowa, my wife's home state, a couple of years ago, and I picked up the *Des Moines Register Tribune*, and saw a great big front page headline about the University of Iowa Medical School undertaking a course in the training of family nurse practitioners, as if this was the newest thing that had ever been heard of and they were the first ones to do it.

And, I thought to myself, "My goodness, we've been doing that all these years in North Carolina. Our Medical Society has looked at this and deemed that under appropriate circumstances, it's something we ought to be doing. Because of their leadership, North Carolina is so far ahead!" And, that's just one little example. There are so many more.

In his speech to the Society almost a year ago, Dr. Harvey Estes, who has served you so well this year and I appreciate so much as Governor of North Carolina, took note of what he called the "serious problems" facing your profession and asked this penetrating question: "I wonder if we as a group will have any role in their solution?"

I am certain that many of you here today share his concern; you wonder whether your profession, after all that it has done, for this Society, for this country, for this state, for every community in North Carolina that you represent, whether this Society will be forced aside in a pell mell rush to tinker with the complex system of health care that we have.

I want to say to you today, strongly and as clearly as I can, that this administration in North Carolina agrees with the conclusion of Dr. Estes that: "The Medical Society is more important and more necessary now than ever before."

And, this administration believes that the job of making good medical care available to all our citizens is too big for



government alone or for the private medical community alone. We need each other.

Put more accurately, the people of North Carolina need us all. We must and we will work together in a spirit of cooperation and dedication.

Throughout its history, this Society has demonstrated a willingness to work with state government, an attitude of helping, a desire to reach common goals for the public good, even though there have been some philosophical differences at times.

Through the years, we have seen this cooperation at the county society level, primarily, and, of course, that's primarily where it ought to be, where you've helped with mass immunization and screening programs, as well as helping to staff local health department clinics.

But, most important, you have been doing the thinking, the looking ahead and the motivating to see that we do for all of our people what needs to be done.

Now, one reason for that is that as physicians you have a special understanding of what's involved in giving people a better opportunity in life.

You have a professional and a moral commitment to that, and every once in awhile I read that oath that you take and I'm so impressed and so grateful.

You know that the wisest investments of our efforts and our dollars are in raising up new generations of people, free of the handicaps that hold back so many people today.

That's why I picked two members of this Society to help direct our efforts in state government toward helping our children, in the most important ways that we do it as a state.

They are two pediatricians: Dr. Sarah Morrow, Secretary of Human Resources and Dr. David Bruton, Chairman of the State Board of Education.

One of the most important reasons that I picked them — I didn't just happen to pick them — one of the most important reasons that I did is that they understand the importance of this emphasis on young children and they are dedicated to carrying it out.

Education is a part of that; child development centers and good families are a part of that; good primary medical care is a part of that.

Now, the reason that I am so personally committed and that this administration is committed, because I talked about this throughout the campaign, to raising up new generations of people who don't have those handicaps, who aren't held down and thus holding us all down.

I think it's for two important reasons and it really goes to the issue of what Charles Brantley Aycock said as we began this century in North Carolina when he urged that we have a state in which every citizen could burgeon all that is within him.

I think it's for two reasons:

Number one, I believe that we have a moral responsibility to help every human being that needs helping, to relieve suffering, and I know that you feel that more strongly than I do.

But, number two, and as an economist, I know that if we are going to move ahead, and I care about where we stand in per capita income — I recently led a trade mission to Europe as many of you know and it's rather startling to go to Europe, and I hadn't been there really to spend any time in many years, and find that a continent that many Americans still think is trying to come back from World War II without making a lot of progress, in fact is thriving economically in many areas more than we are; to find that four countries in Western Europe have a higher standard of living than we have in the United States of America; to find that many of those countries have a lower infant mortality than we have in

this nation; to find that many of them have a longer life span than we have in this country — that shocks you.

It makes you realize that we're in competition in a real sense in terms of what kinds of opportunities we're going to provide.

The second reason, as I said, is that we do, if we're going to make economic progress in this state, we simply have to develop a healthy people who instead of pulling us down and using the taxpayers' money on welfare and in so many hundreds of ways, will turn into producing, healthy people, rather than costing us, all of us, in so many different ways.

I believe that our most serious health care problems in North Carolina occur in areas and in population groups where there aren't enough practitioners to provide medical services for those people who need them — who need them but don't have the money to pay a doctor.

The local people are turning to the state and federal governments for help in such underserved areas and we have to meet those needs.

Our economic future depends on it and I think our moral conscience demands it, and I know you feel that way.

Now, our public health departments can help to meet that, but they only play a very small part in the whole scope of things and that's all they should play, but the last legislature appropriated money to help do that.

But, I want to make it very clear to you in saying this morning, just as clearly and as strongly as I say to you that every citizen in this state must have adequate health care, I want to also say to you that public health should only supplement the private medical community.

Its role should only be to meet those needs that the private medical community alone cannot meet.

It should be the extended arm of the physician to help him serve the people, especially the poor, and to do certain things that the private physician simply cannot and ought not to do.

For example, the poor have needs that are far more than just medical care and these are one of the reasons that they're cost associated.

For example, one of them is simply to prod those who are poorly educated — many of them have no education — simply to keep appointments to get the kind of attention and help that they need to have and that may take call after call after call and even personal visits.

They often have to follow-up after visits to a physician to make sure that prescriptions are filled and medicine is taken properly.

And, it's easy to say, "Well, if they don't want to take it, that's too bad!"

It's not just too bad, they're pulling us all down if they make those decisions.

They need help with transportation and with somebody keeping the children, and with food and clothing and shelter.

I know of one case where the public health personnel had to help an elderly lady get an apartment on the first floor of a housing project because she couldn't climb the steps.

All of those social needs that impinge on health care.

But, it's essential that public health do this and do what is needed and is appropriate in that local situation, with the cooperation and the support of the local medical society, both in defining the need and in determining how it ought to be achieved in that particular community.

For one thing, it will be impossible to find the gaps in medical care without us all working together. For another, we would like to see temporary personnel who are filling needs in underserved areas be replaced by permanent, local, private practitioners.

I've talked to a lot of my physician friends in North

Carolina in the last several days about many things; one of them just yesterday down in the Albemarle area of our state.

Bill Hilliard represented your President, Dr. Harvey Estes, in meeting with me this week in my office. He told me about the situation where a doctor getting only \$4.50 from Medicaid per office visit, had an office overhead of \$4 per visit and that's pretty reasonable overhead, I would guess. He can see four patients an hour and since he's clearing only fifty cents a visit, he's making \$2 an hour on those four patients — substantially under the minimum wage.

Anybody can understand why in that kind of situation private physicians with all the responsibilities that he has, must limit how many Medicaid patients he can see.

I'm told that in many cases the health departments may be getting more reimbursement from Medicaid for patients on a cost basis than does the private physician and that's an area we must explore because we've got to be fair.

The misunderstandings that we may have seen with regard to the role of health departments in providing care to the unserved, I think sometimes grows out of a breakdown in communications that has occurred as, in part, local physicians have been replaced by non-medical administrators of local health departments.

Ten years ago, for example, 57 of our 80 local health department directors were physicians. I would guess that many of them would have come to this convention and would have been very much a part of all of your affairs, statewide and local. This year, only 26 of the 82 department directors are physicians.

Now, in order to prevent those communication breakdowns, I believe we need to build in a permanent mechanism to make sure that local health departments in every county in North Carolina are working hand-in-glove with their local medical societies.

To begin with, I believe that every non-physician health department director should regularly meet with the executive committee of the local medical society.

That would be a vehicle for permanent communication, regular communication. You know, we have to plan for that kind of thing. Some of us find we have to plan for regular communication with our spouses!

And, we surely have to plan for it in these kinds of areas.

I want to urge you very strongly at the local level, and that's the primary thing you know for in Raleigh and in the capital we talk so much about things at the state level and so forth and so on, and part of our problem is we don't think local enough.

I'm glad I grew up and my home remains in Wilson County and I live in a rural community called Rock Ridge and whenever they talk about a problem I say, "Hey, now tell me how that's going to affect us at Rock Ridge?" and if they can't explain that, then they haven't thought it through enough.

What I want us to do is to have a situation that works in Wilson County and in 99 other counties in North Carolina and I want to strongly urge that we do this.

For the long run, I support the recommendations of Dr. Estes that a primary medical care task force, representing the private and public sectors, be appointed to study this issue and prepare recommendations by early fall to be submitted to Dr. Sarah Morrow.

As I have already said to Dr. Estes this morning, I stand

ready to work with your leadership of this Society, to have such a task force appointed and charged.

Let me say a brief word here about the federal requirement that North Carolina have a Certificate of Need law.

I think you are aware that the United States Supreme Court has refused to hear our case. If North Carolina does not have a law by July 1, we stand to ultimately lose up to \$60 million which supports V. D. programs, community mental health programs and alcohol and drug abuse programs, among others.

Obviously, we can't afford to lose that kind of money. We must be sure, however, that Certificate of Need legislation preserves the rights of doctors to treat their patients with a minimum of government interference.

In all of this, we see that delivering all the health services demanded of you, and I know that those demands have increased not arithmetically, they have increased geometrically; the demands of people for services of all kinds seem to have done that, but particularly in this area. Meeting those demands is not an easy task.

There are human problems involved and human problems don't lend themselves to easy solutions. They don't lend themselves to short hours and they don't lend themselves to happy spouses a lot of times.

It's always harder when you care about people, and you deeply, earnestly care about every one of those human beings; you care about the lives they live and the opportunities that they and their families have, but that's what you're like and that's one of the main reasons that you're physicians.

Perhaps our wonderful friend, Dr. Ed Beddingfield, expressed that best in his inaugural address as President of this Society nine years ago when he said:

I believe that most of us do a good job in the private practice of medicine, in our prime duty of taking care of our own patients, but I say to you today, every single one of us has a larger responsibility. After we take off the white coat and depart from the office or the hospital, we are not for the moment in the private practice of medicine, but we are then medically knowledgeable members of the community. It has been said, "We are in the public practice of medicine and we must be both responsible for and responsive to the public interest — in the broadest sense!"

In addition to efforts that are purely local through our local societies, schools, civic organizations and churches, I submit that it is through the vehicle of this State Society that we might become maximally effective in this public practice of medicine.

My fellow North Carolinians, and a group of leaders in this State who are very special and so critically important for our future, let us work together in that spirit. Thank you.

[Whereupon the entire assemblage again accorded Governor Hunt a standing ovation.]

**PRESIDENT ESTES:** Governor Hunt, I'm sure that I speak not only for this Society, but the medical profession as a whole, in pledging that we will work together with you and your administration to help solve these difficult problems that face us.

We appreciate very sincerely your being here and your leadership in our behalf and on behalf of the people of this state.



# General Sessions

## FIRST GENERAL SESSION FRIDAY MORNING SESSION

May 5, 1978

### SURGICAL SESSION

The First General Session of the 124th Annual Meeting of the North Carolina Medical Society convened at approximately nine-ten o'clock in the Cardinal Ballroom of the Pinehurst Hotel, Pinehurst, North Carolina, Dr. E. Harvey Estes, Jr., President of the Medical Society presiding.

PRESIDENT ESTES: Ladies and gentlemen, I would like to call the First Scientific Session of this meeting of the North Carolina Medical Society to order.

I have the distinct privilege of introducing my boss, the Dean and Associate Provost of Duke University Medical Center, Dr. Ewald Busse.

I think "Bud" Busse is well known to most of you in this room. He is a psychiatrist and prior to his assumption of his present role, he was the Chairman of the Department of Psychiatry at Duke.

As you also know, he is an internationally known expert in the area of aging and aging research and he is the founder of the internationally known Center for the Study of Aging at Duke.

Dr. Busse will make a few remarks at the beginning of this scientific session and then introduce our next speakers.

DR. EWALD W. BUSSE [Associate Provost and Dean, Medical and Allied Health Education, Duke University Medical Center, Durham, N.C.]: Thank you, Harvey. It is a pleasure to again return to this very, very excellent meeting and have an opportunity to make a few remarks about what's going on at Duke.

For those of you who are interested in continuing education, I think you know that we, at Duke University Medical Center, have been concerned for many years that we do not have an adequate facility in order to do the type of continuing medical education for physicians and the health professions which we really need if we are going to do our task effectively.

Several years ago, through a grant from the Mudd Foundation, we were able to build the Communications and Library Building, known as the Sealy Mudd Building and we left one floor vacant because that is where we want to put our continuing education effort.

We had a search, and Bill Anlyan had a search for a number of years, until the Searle Company last summer gave a million dollars to complete this continuing education floor of the Sealy Mudd building.

I wish to show you some of the slides of it because it will be completed in August of this year and we hope it will be functioning very well for all types of medical meetings and other health professional groups immediately in the fall.

This is the Mudd Building at the level that most of us enter as we come from the hospital. It is really the third level of this very, very useful building, the Sealy Mudd Communications and Library Building.

The next slide shows the level at which people will be entering to get into the communications level, into the Searle Communications level.

The next slide — will illustrate the floor plan, a rough one, of that floor. I wish to point out to you that in addition to the large auditorium which will be able to hold 470 maximum seating and as you'll see on the next slide.

The key to this particular floor is that it will have, in addition, five conference rooms that can hold anywhere from 95 to 100 participants. It will have very, very excellent audiovisual communications system, TV, closed circuit TV, communication with the hospital and so forth which should make it extremely effective.

I also want to mention that on this floor for those of you who get to visit it in the future, don't forget that the new so-called medical book store is located also on this floor.

In devising and creating this new book store, it was our hope that this would become the foremost medical book store, in the southern part of the United States if not the United States, and I think if you visit that book store, you'll really discover that it is an excellent place to browse and you'll pick up a lot of good medical knowledge that you wouldn't have an opportunity to do otherwise.

Now, the last slide will give you the alternatives of the massive auditorium. It is in four different possibilities.

It is devised like a lot of the more modern educational centers in that it has great flexibility. It will be able to seat for dinner about 370 people very comfortably. It can be altered in many ways.

It can be reduced to about 250 people which then gives a large, on another level, lounge area, seating area and as I've already indicated, if that is put in the seating area it can go to 470.

In effect, what we hope we'll be able to do is have a unit in which we can hold receptions and dinners, as well as very effective educational efforts.

It's obvious that we owe a great deal to the Searle Corporation for their generous donation and I know it will benefit all of us in North Carolina in the years ahead.

I do want to comment on this particular program and upon Dr. Harvey Estes. He, in our opinion, and particularly mine, has been a very, very effective President of the North Carolina Medical Society.

I do want to say that as a Dean of a Medical School, I am very proud of North Carolina and particularly the Medical Society.

For those of you who are active members, you probably don't know that you are recognized throughout the United States as one of the most progressive and farsighted Medical Societies of any state and I believe it is clearly reflected in all of the great things that this group has done.

It really is not looked upon as one who does not look at modern innovations and the needs of people and I think our leadership through the years, including Harvey Estes, and the continuing leadership will make this Medical Society, and will continue to make it one that is really looked upon and admired by the rest of the profession throughout the United States. It's a pleasure to be a member of such a group.

I do now want to make a few comments about the program ahead. I really want to address myself to the moderator, Dr. David Sabiston.

Dr. Sabiston, as you know, is Professor and Chairman of our Department of Surgery. He clearly is a distinguished individual.

I think you know that he is a native of North Carolina; that he is a graduate of the University of North Carolina at Chapel Hill; that he received his M.D. degree from Johns Hopkins and he remained on their staff there, the house staff, and then through on to the faculty for a good many years which was interrupted by a few years while he was in the Armed Forces. But, it is very evident that he is an unusually gifted person.

He is not only a competent surgeon, a scientist, author, editor of a number of textbooks, including "Christopher," which from my viewpoint is particularly useful because I have to quickly look up things and it is an excellent reference book for my uses.

He has published numerous scientific articles. But, I think, even beyond that, if you look at what he has done in his career as a member of various surgical groups.

I think you know that he has just concluded his presidency of the American Surgical Association; he has in the past been Chairman of the Board of Governors of the American College of Surgeons; he has been president of the Society of University Surgeons; he has been president of the Society of Surgical Chairmen and the president of the Southern Surgical Association. So, he remains a very busy person.

But, I do have to make a very personal comment before I turn the meeting over to Dave. He's extremely conscientious. When he serves on the committees of Duke University Medical Center, he does his homework, he reads very carefully, he writes very effective notes, and he comes always prepared and he always brings very sound judgment with very good reasoning.

So, I think you can appreciate why we all love to have Dave around. It's a pleasure to turn the meeting over to Dr. Sabiston!

DR. DAVID C. SABISTON, Jr. [James B. Duke Professor, Chairman, Department of Surgery, Duke University Medical Center, Durham, N.C.; Moderator of Surgical Session.]:

Thank you, Dr. Busse. I'm most grateful for those generous remarks.

First of all, let me say to you on behalf of the Department of Surgery, how grateful we are for the opportunity to present this program this morning.

(The presentations which followed as papers on the Surgical Session program were submitted to the *North Carolina Medical Journal* for possible publication. The speakers and the title of their respective papers were as follows.)

#### **SURGICAL SESSION**

Department of Surgery, Duke University Medical Center, Durham

MODERATOR: David C. Sabiston, Jr., M.D., James B. Duke Professor and Chairman, Department of Surgery, Duke University Medical Center, Durham

#### **OPENING REMARKS:**

Dr. Ewald W. Busse

Associate Provost and Dean

Medical and Allied Health Education

Duke University Medical Center

#### **THE PRESENT STATUS OF HYPERALIMENTATION**

John P. Grant, M.D.

#### **HYPERPARATHYROIDISM: SURGICAL MANAGEMENT AND RESULTS:**

Samuel A. Wells, Jr., M.D.

#### **CURRENT STATUS OF REPLANTATION OF DIGITS AND EXTREMITIES**

James R. Urbaniak, M.D.

#### **OPTIMAL MANAGEMENT OF CARCINOMA OF THE COLON**

William W. Shingleton, M.D.

#### **SURGICAL MANAGEMENT OF THORACIC AORTIC ANEURYSMS**

Walter G. Wolfe, M.D.

#### **SEVERE MULTI-SYSTEM TRAUMA: RESULTS**

Joseph A. Moylan, M.D.

#### **RECONSTRUCTION OF THE BREAST FOLLOWING MASTECTOMY: CURRENT STATUS**

Nicholas G. Georgiade, M.D.

#### **THE ROLE OF NONINVASIVE RADIO-NUCLIDE IMAGING IN SURGICAL DIAGNOSING**

Robert H. Jones, M.D.

#### **SURGICAL MANAGEMENT OF MYOCARDIAL ISCHEMIA**

Andrew S. Wechsler, M.D.

PRESIDENT ESTES: I think you will all agree with me that we have heard an exceptional and very informative program and we thank Dr. Sabiston and his speakers for bringing this to us today. Thank you all.

One brief announcement is that the Emergency Medical Section of the Society is maintaining throughout this meeting a life support station in room #125 to the left, I believe and through the lobby. This life support station has two functions.

Number one, it is there for any needed emergency services that might arise during the meeting and, the second reason, we hope that any member of the Society who needs any brushup on his own cardiopulmonary resuscitative ability will go by and they will be glad to watch you as you function on a mannequin and to criticize and instruct.

So, its purpose is two-fold; not only to respond but also to give you a refresher on your own cardiopulmonary technique.

(The meeting adjourned at twelve-forty o'clock.)

### **SECOND GENERAL SESSION SATURDAY MORNING SESSION May 6, 1978 MEDICAL SESSION**

The Second General Session of the 124th Annual Meeting of the North Carolina Medical Society convened at nine-five o'clock. Dr. Josephine E. Newell, First Vice President of the Medical Society, presiding.

CHAIRMAN NEWELL: Welcome to the Second General Session of the 124th Annual Meeting of the North Carolina Medical Society.

At this time, we're proud to say that the University of North Carolina School of Medicine is presenting the Medical Session of the General Session and I'd like to turn the podium over to Dr. Robert L. Ney who is our Moderator today.

DR. ROBERT L. NEY [Professor and Chairman, Department of Medicine, UNC School of Medicine, Chapel Hill, N.C.; Moderator of the Medical Session]:

The session has been put together by the Medical School of the University of North Carolina Department of Medicine and my job this morning is just to introduce a group of very fine speakers.

The first speaker is Dr. Christopher Fordham, who I'm fortunate to serve in his capacity of Dean of the School of Medicine.

DR. CHRISTOPHER C. FORDHAM, III [Dean, University of North Carolina School of Medicine, Chapel Hill, N.C.]:

Good morning, colleagues! The introduction to the program will be mercifully brief so that you can get on with the science of the morning. I would like to express to Dr. Newell



and Dr. Estes and to the Society appreciation for the invitation to participate in the annual meeting.

I believe that this series of general sessions put on by and rotated through the medical schools is another expression in North Carolina of the closeness of our practicing and our academic communities and how they intertwine and work together. It is a gracious expression of mutual respect and we appreciate the opportunity.

In this time of high criticism of the professions in general, and of our profession, it is a good thing to live in North Carolina.

I think that in our state we are making real progress on a number of important issues that relate to medical care.

Just to give you a specific example, the number of non-urban physicians in North Carolina is up by 13.4 per cent in the past six years compared to the national average of less than a third that figure.

We now, or very shortly, will have a first year residency in the state for every graduating student in the state and large numbers of these first year positions are devoted to primary care and family medicine.

We have developed across the state a regionalized health education program which you're all familiar with which has become a national model and represents important partnerships in our state; partnerships between the academic community, practicing community; partnerships between community hospitals, physicians, trustees, administrators, community colleges and so on, to ultimately result in better access to medical care and the support that is needed to give good medical care.

And, withal, considering the great progress we've made, I think, in numbers of physicians, distribution of physicians, residency programs, in relating to the other health professions, in relating to each other, we have maintained in our state a very strong science base and this is essential.

Emblematic of that science base, as far as I'm concerned, is the Department of Medicine at Chapel Hill.

We recently dedicated, as some of your who are alumni will know, the new Barnett-Womack Clinical Sciences Building, dedicated to the founding chairman of the departments of medicine and surgery at Chapel Hill, Dr. Charles Barnett and Dr. Nathan Womack.

They were both very special people. Dr. Barnett had a very high set of standards about what medical education should be, about investigative medicine, about the care of patients and he was a marvelous fellow, just as was Dr. Womack and it was a great joy, really, to participate in dedicating that building to them, who set the tone and tenor of the clinical departments.

As you know, Dr. Barnett left the chair in the early sixties and he was replaced by Dr. Louis Welt, who served until the early seventies and Dr. Robert Ney is our Chairman and I think we've been very fortunate in the quality and leadership we've had over the years.

Dr. Ney, in my judgment, is one of the finest departmental chairmen in the important specialty of internal medicine in the entire country.

I believe that the department is an exceedingly well balanced department in the sense that they're thoroughly devoted to the things for which there are no immediate academic rewards having to do with extending oneself teaching students, house staff, the sensitive and humane care of patients, as well as scientific achievement, and I believe they score well on all counts and I'm very proud indeed to be associated with the department and to have them present the program this morning. Let me thank you again for the opportunity to do so.

(The presentations which followed as papers on the Medi-

cal Session program were submitted to the *North Carolina Medical Journal* for possible publication. The speakers and the title of their respective papers were as follows.)

## MEDICAL SESSION

Department of Medicine, UNC School of Medicine, Chapel Hill

MODERATOR: Robert L. Ney, M.D., Professor and Chairman

Department of Medicine, UNC School of Medicine, Chapel Hill

## OPENING REMARKS

Christopher C. Fordham III, M.D., Dean, UNC School of Medicine

## THE APPROACH TO THE PATIENT WITH MUSCLE DISEASE

Colin D. Hall, M.D., Associate Professor of Neurology, UNC School of Medicine

## PNEUMONIA: NEW PROBLEMS (LEGIONNAIRE'S DISEASE) AND PROSPECTS (PNEUMOCOCCAL VACCINE)

Terrence J. Lee, M.D., Assistant professor of Medicine, UNC School of Med.

## HODGKIN'S AND NON-HODGKIN'S LYMPHOMAS

Robert L. Capizzi, M.D., Professor of Medicine, UNC School of Medicine

## BYSSINOIS: DISTINGUISHABLE FROM CHRONIC BRONCHITIS

Mario C. Battigelli, M.D., Professor of Medicine and Epidemiology

UNC School of Medicine

## UP-DATE ON ANTICOAGULANT THERAPY

Harold R. Roberts, M.D., Professor of Medicine and Pathology

UNC School of Medicine

CHAIRMAN NEWELL: I know I express the thoughts of every person who has been privileged to hear this fine panel today that we are very deeply grateful to all you gentlemen. And, I want to tell you that our good friend and late colleague, Oscar Sapp, was Commissioner of this Annual Convention and we've missed Oscar in so many different ways, but I know he's perched up on a cloud somewhere with a big smile on his face and saying "I'm proud of those boys!" because I'm sure he is.

At this time it is our privilege to hear from the President of the North Carolina Medical Society and, as you know, Harvey Estes is a cardiologist of great renown. He's Chairman of the Department of Community and Family Medicine at Duke University.

He has a tremendously wide spread set of interests. His advice is sought at all levels of medicine, both as a cardiologist and on socio-economic matters, socio-political matters and he's on so many national committees and travels so much that every now and then we reintroduce him to his wife, Jean.

He has a tremendous ability to digest tremendous volumes of bureaucratic material and reduce it down to concise language that the rest of us can understand.

He's a brilliant, determined, frank, gallant gentleman whose leadership we have enjoyed throughout the past twelve months.

The President of the North Carolina Medical Society, Dr. E. Harvey Estes, Jr.

[Whereupon the entire assemblage then accorded President Estes a standing ovation.]

PRESIDENT ESTES: Thank you, Jo! You know you can't believe her anyway!

I think all of us would agree that medicine remains an art

and that the best of science, technology and methodology can fail if the physician is unable to blend it into his practice in a manner which provides for the patient confidence and reassurance.

[President Estes' "annual Address of the President" was published in the *North Carolina Medical Journal*, May 1978, Vol. 39, No. 5. Following presentation of his address, President Estes was again accorded a standing ovation.)

CHAIRMAN NEWELL: Thank you President Estes. I think he's a great leader.

At this time, we would like to remind you all what a tremendous effort there is on the part of the headquarters staff to put on this meeting. Even that little program in your hands takes a year's effort and so if you get the chance, speak to them and thank them for what they do for us. They are hard-working people.

[The meeting adjourned at twelve-thirty o'clock.]

### THIRD GENERAL SESSION SUNDAY MORNING SESSION May 7, 1978 SOCIO-ECONOMIC SESSION

The Third General Session of the 124th Annual Meeting of the North Carolina Medical Society convened at nine-thirty-two o'clock, Dr. R. Bertram Williams, Jr., Second Vice President of the Medical Society, presiding.

CHAIRMAN WILLIAMS: Ladies and Gentlemen: The Third General Session of the 124th Annual Session of the North Carolina Medical Society is called to order.

It would perhaps be improper for us to have a subject such as we will discuss this morning without at least an attempt at an appropriate statement for this occasion.

In making such a statement, I would like to quote one line from an address made by Dr. William Osler. This address you're all familiar with. He made this at Johns Hopkins University as his farewell address, as he left Johns Hopkins and accepted the Chair of Medicine in one of the big institutions in England. As you know, he was later knighted.

And, the one sentence I would like to quote is this: "We have here to add what we can to life, not take what we can from it."

As you all know, there is a very deep meaning in that statement.

Perhaps this is the source of the idea that President John Kennedy drew his statement that has received so much publicity as part of his inaugural address.

### CONJOINT SESSION

I'm sure that those of you who attend this meeting regularly, as do I, look forward to our next speaker. His calm, studious manner and impeccable appearance instill confidence.

It is always an enjoyable opportunity to have him share with us his great knowledge of public health activities in our state, and his great wit.

With pleasure I introduce from the North Carolina Division of Health Services our colleague, the State Health Director, Dr. Jacob Koomen.

DR. JACOB KOOMEN [Director, Division of Health Services, North Carolina Department of Human Resources]:

Dr. Williams, I so appreciate your kind remarks and your kind thoughts. I had really planned to do this in a fashion described these days as "straight" from this podium in serious vein and sticking strictly to the material at hand, superbly written by Dr. J. N. MacCormack.

[Whereupon Dr. Koomen then presented his prepared

address which has been submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN WILLIAMS: Thank you, Dr. Koomen. Your remarks are always very informative, very interesting and you are never a disappointment.

Our next presentation is supported by the Joseph W. Hooper, Sr. M.D. Fund made available to the Society by the family and friends of Dr. Joseph Hooper.

Dr. Hooper was a practicing general surgeon in my home town of Wilmington and, in fact, was my family general surgeon until his death. He was small in stature but a giant in his home town. He was an outstanding surgical diagnostician, a superb technician and gifted with the old fashioned art of bedside manner.

To introduce the Joseph W. Hooper Sr. Lecturer I'll call on Dr. John Glasson.

DR. JOHN GLASSON: Thank you, Bert. Dr. Theodore Cooper, a native of New Jersey, a graduate of Georgetown University Undergraduate School, St. Louis University Medical School 1954, with training in cardiology and surgery at St. Louis University and at the National Heart Institute; Ph.D. in physiology, St. Louis University; he has been professor of surgery at St. Louis and the University of New Mexico.

He has been Professor of Pharmacology and Chairman of the Department at the University of New Mexico 1966; Director of the National Heart Institute 1968.

Then in 1975, served as Assistant Secretary of Health under the Ford Administration.

I'm proud to say that Dr. Cooper is now Dean at my alma mater, Cornell University Medical College and also serves as Provost of Medical Affairs at Cornell University. I know of no person who has a better grasp of the socio-economic affairs of medicine than Ted Cooper.

He has been on the firing line from the standpoint of government. As you can see by his credentials, he is a doctor's doctor and without further ado, in view of the fact that he does have a tight schedule, I will eliminate a few anecdotes about him and introduce Ted Cooper.

DR. THEODORE COOPER [Dean, Cornell University Medical College, New York]: Thank you, Dr. Glasson.

Ladies and Gentlemen:

I thought it was only fitting for Cooper to give the Hooper Lecture, so when Dr. Glasson called me, when I was unemployed last year, having recently been fired as a result of an election, I was delighted to get the opportunity to come to this lovely setting.

I am a follower of the links and had heard about this lovely set of golf courses.

I do not know very much about Dr. Hooper, but in checking into it, I am honored indeed to enter the list of lecturers that will honor his name. I thank his family for the opportunity to visit.

I have also followed for a considerable period of time because I had to, if for no other reason, the purposes and policies, the practices and programs of your Society and those of many of the medical institutions in this great state.

In my previous incarnations I even had occasion to do battle with some of the suits that you entered upon some of my former institutions in the name of the welfare of the people and in the integrity of the profession.

In fact, perhaps if I came as a government official, I would not be as relaxed and purposeful as today, because I know you have thought out the issues and do not take the combat lightly.

[Dr. Cooper's prepared address has been submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN WILLIAMS: Thank you, very much, Dr.



Cooper. We are certainly fortunate to have a man such as you who can help us to focus on the issues after walking through the quagmire of bureaucracy and the review of political plumbs.

I would like to call to your attention that this lecture has been recorded and will be made available to you in one form or another, if you so desire.

For our next speaker, I'll call on Dr. David Welton for an introduction.

DR. DAVID WELTON: Thank you, very much, Mr. Chairman. Ladies and Gentlemen:

Please let me take a moment to comment on the rare privilege we are having this morning. We've had a very enlightening and delightful dissertation by our long time friend and colleague, Jake Koomen. We've had a tremendously perceptive analysis dilemma, you might say, by Dr. Cooper.

It is my privilege now to present to you a gentleman who is a trustee of the American Medical Association, which may be the only organization which can, with all of our help, prevent us from falling into that terrible fate that Dr. Cooper just described.

Next, let me tell you just a bit about our speaker, Dr. Hoyt Gardner. You may read the details of his biography in your program and I urge you to do so.

He has an outstanding record of service and leadership in his community, in his state, and at all levels of organized medicine.

He is serving in his second term on the Board of Trustees of the American Medical Association and is currently a very active candidate for the position of President-elect of the AMA, the election for which will occur in St. Louis next month.

Yesterday, for the second time in his life, he was not in person watching the Kentucky Derby in Louisville. He has seen 26 out of the last 28.

So, we are very honored that he decided to come and be with us on this occasion. I'm particularly happy to present to you Dr. Hoyt Gardner of Louisville!

DR. HOYT D. GARDNER [Member, Board of Trustees, American Medical Association.]: Dr. Welton, Mr. Chairman, Dr. Cooper, Colleagues:

It's a great pleasure for Rose and I to bring you greetings from the American Medical Association and from the American Medical Association's Auxiliary.

It's a beautiful day in North Carolina today. God is obviously in his heaven. I assure you the winner is in the barn and there may or may not be money in the bank at home!

In case you do not know what Kentucky is, let me preface the beginning of this by explaining Kentucky to you as we know it at home.

Kentucky is a state that provides three basic essentials of life. In case there's doubt what they are, that's tobacco, whiskey and race horses!

I appreciate the fact that you all value them as we do. I've observed you and I find that you hold them closely.

We hold them even closer for another reason; because that's the way we make most of our money which, in turn, we spend on politics and women and that, of course, explains Kentucky's continual state of poverty! (Laughter)

[Dr. Gardner's remarks submitted to the *North Carolina Medical Journal* for possible publication.]

CHAIRMAN WILLIAMS: Thank you, very much, Dr. Gardner, for your very enlightening remarks.

Our next speaker needs no introduction. We have no better way to show our respect than to elect him President of our Society.

He is a practicing clinician who well understands the problems of those that are sick and those attempting to help them. His home is small enough that he daily shares the joy with the fortunate and shares sorrow with the less fortunate.

He is truly a North Carolina product, native of Durham, graduate of Bowman Gray Medical School, completed with a five year program in surgical residency at Bowman Gray School of Medicine, and an outstanding citizen of Lumberton since 1953.

As a Southeastern North Carolina colleague, I can tell you that he is, among other things, a good, commonsense doctor.

It is with great pleasure that I introduce to you the new President of the North Carolina Medical Society, Dr. D. E. Ward, Jr.

[Whereupon the entire assemblage then accorded newly elected President Ward a standing ovation.]

PRESIDENT WARD: Dr. Williams, Members of the North Carolina Medical Society, Ladies and Gentlemen, and Guests:

[Whereupon President Ward then presented his Address of the Incoming President which was printed in the *North Carolina Medical Journal* June, 1978, Vol. 39, No. 6. Following his address Dr. Ward was again accorded a standing ovation.]

CHAIRMAN WILLIAMS: Thank you, very much, D. E. We, as members of the Medical Society, look forward to another very successful year under your leadership.

At this time, I would like to do something a little unusual, if I may.

I'd like for Harvey Estes to stand and, Jean, would you also stand?

[Whereupon Dr. and Mrs. Harvey Estes stood up to be recognized.]

This is a little in reverse. Let's remain seated and give them a hand for their great contribution this past year. We thank both of you.

At this time, I would like to officially bring the 55th Annual Session of the Auxiliary to the Medical Society and the 124th Annual Session of the North Carolina Medical Society to a close.

Thank you all for attending.

[Whereupon the meeting adjourned sine die at twelve-seven o'clock.]

# President's Dinner

SATURDAY EVENING SESSION

May 6, 1978

The President's Dinner at the 124th Annual Meeting of the North Carolina Medical Society convened at seven-fifty o'clock in the Cardinal Ballroom of The Pinehurst Hotel, Pinehurst, North Carolina, Dr. Josephine E. Newell, First Vice President of the Medical Society, presiding.

CHAIRMAN NEWELL: Good evening! It is my great pleasure to welcome you all to the President's Dinner honoring E. Harvey Estes, Jr., President of the North Carolina Medical Society.

At this time, I would like to recognize Dr. Bert Williams, Second Vice President of the Medical Society, who will offer the invocation.

DR. R. BERTRAM WILLIAMS, Jr. Second Vice President, Medical Society: Will you lower your heads please?

For life, for health, for happiness, for intelligence, for ambition to improve and contribute, for the contributions of countless previous generations ahead of us, for concerned and involved persons in this room, for people who need us, for the privilege, ability and willingness to help others, in distress, we give our thanks.

Bless this food to nourish our bodies that we may better carry out our responsibilities.

We ask in His name, Amen.

Whereupon the banquet followed with the meeting being resumed approximately one hour later.

CHAIRMAN NEWELL: Dear friends, may I have your attention please! I hope everybody has been served dessert and we're going to start so that you light-fingered and light-footed ones can commence to dance in a few minutes!

You know, a lot of folks would think and I would think, that after the boondoggle I made in the leadership conference banquet, that a brilliant man like Harvey Estes would have had a whole lot better sense than to make me Master of Ceremonies tonight, but it just goes to prove what a mind-boggling experience being the President of this Medical Society can be and twelve months of misery.

And, you know, the worst part about this is that for a long time now we've all been noticing that sneaky smile that Harvey has, you know, and every time he thinks about it that after tonight it's all over!

Well, it's not so, Harvey, old buddy!

Along came Jesse Caldwell and Jesse, you know, is that kind who loves to bust everybody's balloon and he said, "Harvey, old boy, it's just starting! Now, you're going to be the immediate past president, the alternate delegate to the AMA and better yet, the secretary of the mediation committee!"

And, I looked into it before I left home and I found out that lo and behold, thank goodness, Duke University still claims him and he can keep on being chairman of the department there to make a living with. He's been gone an awful lot these past two years though and so, we're real proud they've kept him on.

Now, his balloon got completely busted for he found out something that all of us old maids have always known:

Anticipation is greater than realization!

Now, I want you to know that Harvey is my boss in more ways than one and I had to take a solemn oath to behave tonight, and I'm doing it! Now, you watch, I'm absolutely doing it! I thought I was very dignified just before you all

waved and somehow or other I've gathered up a cloak of dignity that you'll recognize tonight — all that I could master for this occasion!

Harvey and I only had one little misunderstanding about this banquet tonight.

You know, Harvey just didn't understand that I couldn't let them call me the "Mistress of Ceremonies"!

Now, friends and colleagues, can you imagine explaining to a nice, quiet, honest, faithful, husband and father of five children — and all at home, I think — that no old maid in the whole world is going to let you call her a mistress for any reason, and there ain't no way is she going to let you call her a madam, I'll tell you that!

You know, I've been coming to these meetings for thirty years. Now, that has nothing to do with my age. It just goes to prove that you can graduate from medical school at a very early age and join the Medical Society; — laughter — not true for some of my colleagues who have been with me, like Jack Hughes, all the time I've been here and some of them have entered the middle age; silver hair, gold teeth and lead butt!

But, in these thirty years, I have noticed that this banquet has always been emcee-ed by male chauvinists. In fact, the whole convention is.

Introductions always go like this:

Dr. James E. Davis — and his wife, Margaret!

Dr. John Glasson — and his wife, Ella!

So, as the Bible says, all things come to him who waits and I've been waiting a long time!

And, tonight I'm declaring this is Ladies' Night and this is the First Lady's Banquet!

Now, you know, I've always wondered how the nominating committee can keep coming up with these marvelous people to be president and just like you all are, I'm looking forward to another outstanding year when D. E. Ward is the president, but I do dread to see Harvey's administration end for a lot of reasons and I'm going to tell you why.

Can you imagine how in the world are we going to teach that straight-laced "Down Easter," D. E., how he's ever going to learn to talk bureaucratic!

I tell you what's the truth, Harvey was what you call a "quick study"; that's right and just to prove it, I want to show you all a memorandum I got from him on April 10th — there it is on that Medical Society stationery and he did this after only eleven months in office.

Okay, it's dated April 10th, 1978 and it says — D. E., you'll have to memorize this one. It's too good to lose.

All the delegations and redelegations made pursuant to the previous delegations of the authorities now delegated to you by this delegation continue in effect until otherwise superceded, and this delegation is effective immediately and may be redelegated.

Now, the only real job I have here is to introduce you all to some of my good friends whom every one of you know, but I'm going to take advantage of the situation anyhow and when I finally give you their names, they'll briefly rise and then you'd better sit down because I may have more to say about you, you might not want to hear!

On my right, is the First Lady of the Medical Society, Jean



Estes, and her husband, Harvey!

When introduced, each person stood to be recognized and were applauded by the audience at the time of their introduction.

And, next, down the row there, that lovely lady you see is the wife of the Second Vice President, Ellen Williams and her husband, Bert!

Next is Mary Leila Andrews and her husband, Bob!

And, Mary Jane Means, and, your husband Bob! She's incoming president of the Auxiliary.

Now, on my left is this lovely lady, the First Lady Elect, Sara Ward, who shortly is going to allow her husband, D. E. to take the oath of office and be the president of this group.

The First Lady Elect, Sara Ward and her husband, D.E.!

Now, next to D. E. Ward over there, is a pretty, always cheerful, ever energetic, the most pleasant lady I think I've ever met in my life, Ella Glasson and John!

Now, on John's left is a lovely lady who has been a most welcome guest before to the North Carolina Medical Society on several occasions. We're always glad to have her and she's Rose Gardner and her husband is Hoyt.

Now, you know, that everybody has always known that behind every successful man is a strong woman and Rose Gardner is a strong woman behind Hoyt who finally lifted him to be a member of the AMA Board of Trustees, Vice President of the AMA-ERF and, next year, they're going to come back here as President-elect of the AMA, or her husband is going to come back as the President-elect of the AMA, but Rose, you're still going to be our welcome guest and we're always glad to have you.

Rose Gardner and her husband, Hoyt!

We're also happy to have with us tonight some guests of the Auxiliary.

Mrs. C. H. Gilliland, Southern Regional Vice President of the AMA Auxiliary.

And, Mrs. H. Bruce Martin from Huntington, West Virginia, who's President of the Southern Medical Association Auxiliary.

Now, last but not least — far from least — is our lovely friend down here, Helen Hughes and her husband Jack. He's our Constitutional Secretary.

Now, at this time, I want to call to this podium a most respected member of our Society, John Glasson, who is a Past President of the Medical Society and whose vast knowledge of organizational medicine well qualifies him as both advisor and advocate.

John will present the President's Jewel!

DR. JOHN GLASSON: Jean, Sara — I've had to modify my remarks somewhat tonight!

At each annual meeting of the North Carolina Medical Society and at about this time, according to the provisions of the Constitution and Bylaws, the Society has designated two of its members as President-elect; one about to take office at this dinner and one to take office approximately one year hence.

At any given time, however, the North Carolina Medical Society has only one President, and, though you will not see his name mentioned in the official program for tonight's dinner, it is my obligation at this point in the program on behalf of the North Carolina Medical Society to thank Harvey Estes for his devoted service to the Society during the past year.

By tradition, over more than a century, there are no political campaigns waged by members of the North Carolina Medical Society to be elected to its presidency or to any of its official offices.

Rather, the Society selects each year one of its members as President who has demonstrated by his ability and de-

voted service to the Society the capability to lead us for one year through the ever more complex world relating to the delivery of medical care in the State of North Carolina.

The President is highly honored by his selection but he is also tapped by the Society for a year of extensive travel, hard work and personal sacrifice as he fulfills the duties of his office.

The time required and the difficulty in carrying out these duties seems to grow each year.

Harvey's professional background and many of his honors and accomplishments are listed in front of the official program and I shall, therefore, not recount these except to say that when he became President of this Society, he already had many major administrative duties and major obligations as a member of many national committees concerned with medical care delivery.

Nevertheless, he added the responsibility of his office as our President so as to lead the Society through an outstanding year characterized principally by improved two-way communication between the officers of the Society and the membership through the District Councilors in a series of district meetings throughout the state.

Featured at these meetings were discussions of both state and national medically related legislation which has now become so vitally important in the lives of each doctor and his family, as well as the welfare of each citizen.

As Harvey has pointed out, in the field of legislation, you win some and you lose some and some you have to compromise, but the Society and its members must stay constantly involved.

With the Society now in its third year following the institution of mandatory requirements for continuing education for its members, it has been Harvey's job to interpret to the membership in many instances the continuing education requirements and to lead the Society in adopting appropriate policies in the implementation of these continuing education provisions.

He has spent much time in the latter part of his administration in negotiations with both state and federal governments in connection with the efforts to provide primary medical care for our people.

Now, in the last line of the information about Dr. Estes in your programs, you will notice that he is recognized for "conveying to his students genuine interest in their personal lives and development."

Now, Harvey, we want you to know that we of the membership of the North Carolina Medical Society, likewise, have a great interest in the personal lives and development of our leaders.

In order to be completely honest and objective in this presentation, we must include a few items which are perhaps not so well known to the members of the Society.

For this information, we must thank two of the members of our research committee who are sitting at the head table; and, Ella and Jean, we thank you for your help!

Harvey's hidden talents may all be attributed to the fact that in addition to his brilliant mind, he also has "good hands!"

In his earlier years, he was widely known as an award-winning violinist. He makes and finishes beautiful furniture and he has recently led his family in a major project to build personally with his own hands an entire vacation home.

He is an accomplished sailor, devoted fisherman, and with one exception, a dedicated boatsman!

The one exception is a rather large and powerful outboard cruiser with which Harvey has developed almost complete incompatibility!

It seems that whenever Harvey is at the helm, the gears

will only allow the boat to go in reverse and in slowly weaving circles over the lake's surface! It has further come to light that with great effort, our hero has been able on occasion to get the boat to go forward but on these rare occasions, the boat has somehow ended up on top of the dock!

It is said that Harvey's greatest happiness, with respect to this craft, was on one occasion when the unrecognized loosening of its drain plug caused the craft to disappear entirely below the surface of the lake!

The entire matter has now been resolved so that the official skipper of the boat is now Jean Estes with Harvey serving as first mate, silently skimming, with clenched teeth, over the surface of the water!

In addition to his talents as a boatsman, Harvey is an accomplished weaver of hammocks, a gardener of some note and, as a devotee of good physical conditioning, may be found jogging in his home neighborhood almost every morning. We understand, however, that there is a certain St. Bernard who has taken exception to this activity and is now in the process of metabolizing a small portion of our President's pants!

Harvey is a baker of excellent sourdough bread and is accomplished at carrying out all kinds of repair work around the house.

He loves this activity so much that he now has reserved for himself several projects in almost every room of the house!

Harvey has been for us a young and energetic President and, so, in thanking him for his year of service to us, we must observe that, rather than marking the end of a distinguished career, this year probably should be characterized as a high point in the life of a good man, a devoted father and a fine physician and we shall all follow with interest his continued career as a leader in medicine.

So, at this point I would like to ask Jean to come forward with Harvey, to present Harvey the well-earned jewel which he is now entitled to wear and while she pins it on his jacket, let's all stand for a round of applause for our "Good Hands President!"

[Whereupon Dr. Glasson then presented the President's Jewel to Mrs. Estes, who then pinned it on the jacket of her husband.]

PAST PRESIDENT ESTES: John, thank you, very much. What can one say after two introductions like that? I won't try!

Jo, John, thank you, very much! I would like to, while I've got the microphone, this evening, thank every one of you for a great year. I appreciate it very much and I look forward to working with you for a long, long time.

I would also like to recognize two very distinguished guests in our midst that we have been pleased to have with us for the last several days.

First of all, Dr. Charles Davis, President-elect of the Virginia Medical Society, and his wife, Kit! Would you please stand, sir!

Next, Dr. Carl Bergstiner, the President of the Medical Society of Georgia, and his wife, Jackie!

We're delighted to have these colleagues with us and we are happy that you could join us and that we could, at last, bring you a day of good weather! Thank you, very much, for being with us!

Next, I'd like to thank a few people who have been very special to me during the past year.

Of course, it goes without saying that I couldn't have done it without Jean, so I thank her!

I'd like to thank next Bill Hilliard and a staff that I think is unexcelled in this country.

And, I think you all know that Bill would say this, if I didn't say it for him, that he has behind him a tremendous staff of people and I will not introduce each of them individually. You know them all and I want them, each and every one, to know that I appreciate the work that they have done this year for your Society and for me. Thank you.

Next, there are six Commissioners. We don't thank the Commissioners very often. These are individuals who do a great deal of work, they cover a group of committee; they are the liaison between the Executive Council and the committees. They do a tremendous job and I think we recognize them all too seldom.

I would like to ask your six Commissioners who are present—I know some are present and I hope all are present, but I would like to thank them personally. Where are the Commissioners?

[Whereupon the Commissioners, Dr. Redding, Dr. Nelson and Dr. Sohmer, stood up to be recognized.]

Three out of the six, that ain't bad! Thank you, very much.

Next, the ten Councilors, our representatives from the districts who have worked so hard this year to improve the relationships between the various areas of this state and the Medical Society.

I don't know how many of our ten Councilors are present, but I would like for them to stand for a special note of thanks.

[Whereupon those Councilors present stood up to be recognized.]

It has been a great year and I would like to finally thank each and every member who has supported me in every possible way. I have enjoyed the year. I've learned a great deal. I've met a lot of very nice people and I am forever grateful for the honor you have paid me.

I would next like to ask the new officers, with the exception of my friend, D.E., to come forward and stand in this space immediately in front of me so that I might administer the oath of office. Would our new officers please come forward!

[Whereupon the newly elected officers then came forward and assembled in front of the podium.]

I will read the oath of office and then at the end, I would like for each to respond by answering, "I do!"

I SOLEMNLY SWEAR THAT I WILL CARRY OUT THE DUTIES OF OFFICE TO THE BEST OF MY ABILITY. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES OF AMERICA AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY AT ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL MY FELLOW AMERICANS.

What say you?

[Whereupon all the newly elected officers of the Medical Society said, "I do!" in unison.]

Congratulations to you all and I look forward to a great year from all of you.

Next, I would like to ask our friend, Dr. D. E. Ward, to come forward and be sworn in as the new President of the North Carolina Medical Society.

You will repeat after me, please!

PRESIDENT WARD: I, D. E. WARD, SOLEMNLY SWEAR THAT I SHALL CARRY OUT THE DUTIES OF THE OFFICE OF THE PRESIDENT OF THE NORTH CAROLINA MEDICAL SOCIETY TO THE BEST OF MY ABILITY. I SHALL STRIVE CONSTANTLY TO MAINTAIN THE ETHICS OF THE MEDICAL PROFESSION AND TO PROMOTE THE PUBLIC HEALTH AND WELFARE. I SHALL DEDICATE MYSELF AND MY OFFICE TO IMPROVING THE HEALTH STAND-



DARDS OF THE AMERICAN PEOPLE AND TO THE TASK OF BRINGING INCREASINGLY IMPROVED MEDICAL CARE WITHIN THE REACH OF EVERY CITIZEN. I SHALL UPHOLD THE CONSTITUTION OF THE UNITED STATES AND THE CONSTITUTION AND BYLAWS OF THE NORTH CAROLINA MEDICAL SOCIETY AT ALL TIMES. I SHALL CHAMPION THE CAUSE OF FREEDOM IN MEDICAL PRACTICE AND FREEDOM FOR ALL MY FELLOW AMERICANS.

I DO SOLEMNLY SWEAR THAT I WILL DISCHARGE THE DUTIES OF OFFICE TO THE BEST OF MY ABILITY, SO HELP ME GOD!

PAST PRESIDENT ESTES: Congratulations!

[Whereupon the entire assemblage then accorded President Ward a standing ovation.]

PRESIDENT WARD: It is with profound gratitude and deep humility that I accept the office as President of the North Carolina Medical Society.

Medicine today has many challenges, problems, legislative dilemmas and new and greater horizons to obtain.

The North Carolina Medical Society has a proud and honorable heritage of noble and worthwhile service to the citizens of the Old North State.

I would ask that each physician in North Carolina dedicate their efforts and give their support to our Medical Society. Only through our earnest devotion to organized medicine, at all levels, can we, as physicians, enhance our efforts to provide excellent medical care to the citizens of our state.

With trust in God, your Medical Society will continue the humanitarian service of the medical profession to all North Carolinians. Thank you.

At this time, I would like to introduce our family and our friends tonight on this special occasion.

First I would like to introduce our daughter, Sally, who teaches kindergarten in Raleigh and the young man she's too marry July 15th, Robert Jones of Raleigh! Would you please stand!

Our son, David, who is an attorney in Raleigh, and his date, Miss Libby Bynum!

Our other son, Demmy who is a doctor, and his wife, Susan, are serving for two years in a Baptist Mission Hospital in Bangalor, India.

Sara's brother, Edward Henry, an attorney in Lumberton and his wife, Sara!

We also have cousin, Marilyn and cousin Clyde Camp from Lumberton!

At this time, I would like to ask all of the members, their wives and families, of Robeson County Medical Society to please stand and be recognized.

I will now turn this podium back over to Jo who will officially proceed with the program.

CHAIRMAN NEWELL: It says right here, "Announcements," and I know you'll be happy to hear that there are no announcements, other than the fact that you must leave so we can clear the floor for the dance.

Please don't stay very long, it won't take them very long.

We've been so happy to have you here, so let's all go out that door and have a party until they're ready for us again; and, then come on back in here, friends; it ain't raining inside!

So, let's have a good time! Goodnight!

[Whereupon the meeting adjourned at nine-twenty-five o'clock.]

## MEDICAL AWARDS

**Moore County Medical Society Medal**

In 1927 the Moore County Medical Society established a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to compete.

Each Section Chairman selected a committee of three to decide on the best paper in their section. The winning papers are then turned over to the State Committee, who select the one to receive the medal. The following award was made:

- 1971—Herbert J. Proctor, M.D., Chapel Hill  
 "POST TRAUMATIC PULMONARY INSUFFICIENCY"  
 (Section on Surgery, May 17, 1971)
- 1972—Donald C. Mullen, M.D., Charlotte  
 "CURRENT CONCEPTS IN THE MANAGEMENT OF ABDOMINAL AORTIC ANEURYSMS."  
 (Section on Surgery, May 23, 1972)
- 1973—Susan C. Dees, M.D., Durham  
 "THE ROLE OF GASTRO-ESOPHAGEAL REFLUX IN NOCTURNAL ASTHMA IN CHILDREN"  
 (Section on Pediatrics, May 22, 1973, Pinehurst)
- 1974—Herman Grossman, M.D., Durham  
 "PEDIATRIC UROLOGICAL ROENTGENOLOGY"  
 (Section on Pediatrics, May 20, 1974)
- 1975—No Award given—(no papers received)
- 1976—No Award given—(no papers received)
- 1977—Gordon F. Murray, M.D., Chapel Hill  
 "OPERABILITY OF CARCINOMA OF THE ESOPHAGUS"  
 (Second General Session, May 7, 1977, Pinehurst, selected by Section on Surgery)

**The George Marion Cooper Award**

The Fellows of the Wake County Medical Society present the George Marion Cooper Award established in honor of George Marion Cooper, physician and health benefactor.

The medal is awarded by the Fellows of the Wake County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advancement of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medical Society of the State of North Carolina. The following award was made:

- 1971—Takey Crist, M.D., Chapel Hill  
 "ABORTION—WHERE HAVE WE BEEN? WHERE ARE WE GOING?"  
 (Section on General Practice of Medicine, May 18, 1971)
- 1972—John L. McCain, M.D., Wilson  
 "TRAIN YOUR OWN ASSISTANT"  
 (Section on Internal Medicine, May 23, 1972)
- 1973—Elizabeth Kanof, M.D., Raleigh  
 "SKIN CANCER — EDUCATION AND DETECTION AT A STATE FAIR"  
 (Section on Dermatology—May 20, 1973, Pinehurst)
- 1974—William G. Conley, III, M.D., Chapel Hill  
 "URINARY TRACT INFECTION IN CHILDREN"  
 (Section on Pediatrics, May 20, 1974)
- 1975—No Award given—(no papers received)
- 1976—No Award given—(no papers received)
- 1977—Hyman Muss, M.D., Winston-Salem  
 "BREAST CANCER"  
 (First General Session, May 6, 1977 selected by Section on Internal Medicine)

(The Committee on Awards has now been abolished  
 and the Awards are discontinued May 1978)



## HISTORICAL DATA

In the interest of economy the lengthy Historical Data printed in the Transactions will only be printed periodically. Only the information relating to recent years is included here. Should any member desire additional Historical Data,

he may request the information for earlier years from the Medical Society Headquarters Office at 222 North Person Street, (Mail address: P. O. Box 27167) Raleigh, North Carolina 27611.

## HISTORY OF THE NORTH CAROLINA MEDICAL SOCIETY ANNUAL MEETINGS

Date	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	Sec.-Treas.	Members on Roll	Honorary Members	Life Members
1945	No meeting because of O.D.T. restrictions	..	†Paul F. Whitaker	Oren Moore	Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,811	7	383
92 1946	Pinehurst	889	†Oren Moore		Wm. H. Smith Zack D. Owens	Roscoe D. McMillan	1,939	6	397
93 1947	Virginia Beach, Va.	444	†Wm. M. Coppridge	Frank A. Sharpe	G. E. Bell J. B. Bullitt	Roscoe D. McMillan	2,191	7	404
94 1948	Pinehurst	920	†Frank A. Sharpe(†)	James F. Robertson	V. K. Hart J. G. Raby	Roscoe D. McMillan	2,298	8	407
95 1949	Pinehurst	998	†James F. Robertson	G. Westbrook Murphy	Joseph J. Combs Joseph A. Elliott	Roscoe D. McMillan	2,318	5	405
96 1950	Pinehurst	947	†G. Westbrook Murphy	Roscoe D. McMillan	Ben F. Royal Joseph A. Elliott	Millard D. Hill	2,283	5	455
97 1951	Pinehurst	938	Roscoe D. McMillan	Fredenc C. Hubbard	Joseph A. Elliot Henderson Irwin	Millard D. Hill	2,341	5	469
98 1952	Pinehurst	969	Frederic C. Hubbard	J. Street Brewer	Forest M. Houser Arthur Daughtridge	Millard D. Hill	2,326	5	476
99 1953	Pinehurst	1,016	†J. Street Brewer	Joseph A. Elliott	George W. Paschal John R. Bender	Millard D. Hill	2,673	5	486
100 1954	Pinehurst	1,077	†Joseph A. Elliott	Zack D. Owens	John F. Foster Julian A. Moore	Millard D. Hill	2,801	6	486
101 1955	Pinehurst	991	Zack D. Owens	J. P. Rousseau	George W. Paschal, Jr. Elias S. Faison	Millard D. Hill	2,896	6	507
102 1956	Pinehurst	1,022	†James P. Rousseau	Donald B. Koonce	E. W. Schoenheit Milton S. Clark	Millard D. Hill	3,058	7	561
103 1957	Asheville	867	†Donald B. Koonce	Edward W. Schoenheit	John S. Rhodes O. Norris Smith	Millard D. Hill	3,127	8	522
104 1958	Asheville	781	Edw. W. Schoenheit	Lenox D. Baker	George W. Holmes Amos N. Johnson	Millard D. Hill	3,171	9	542
105 1959	Asheville	651	Lenox D. Baker	John C. Reece	Amos N. Johnson Kenneth B. Geddie	John S. Rhodes	3,211	10	251
106 1960	Raleigh	848	John C. Reece	Amos N. Johnson	Chas. M. Norfleet, Jr. W. Walton Kitchin	John S. Rhodes	3,247	12	472
107 1961	Asheville	636	†Amos N. Johnson	Claude B. Squires	Theodore S. Raiford Charles T. Wilkinson	John S. Rhodes	3,248	12	438
108 1962	Raleigh	745	†Claude B. Squires	John R. Kernodle	John A. Payne, III J. Sam Holbrook	John S. Rhodes	3,339	9	425
109 1963	Asheville	714	John R. Kernodle	John S. Rhodes	H. Fleming Fuller Jacob H. Shuford	Charles W. Styron	3,491	9	431
110 1964	Greensboro	677	John S. Rhodes	T. S. Raiford	Wm. F. Hollister F. G. Patterson	Charles W. Styron	3,473	8	398
111 1965	Charlotte	738	†T. S. Raiford	George W. Paschal, Jr.	Hubert McN. Poteat Wayne J. Benton	Charles W. Styron	3,516	8	390
112 1966	Asheville	545	George W. Paschal, Jr.	Frank W. Jones	W. Otis Duck John L. McCain	Charles W. Styron	3,597	12	339
113 1967	Pinehurst	644	†Frank W. Jones	Robert A. Ross	David G. Welton Daniel A. McLaurin	Charles W. Styron	3,606	14	302
114 1968	Pinehurst	623	†Robert A. Ross	David G. Welton	E. T. Beddingfield, Jr. James S. Raper	Charles W. Styron	3,642	13	298
115 1969	Pinehurst	577	David G. Welton	Edgar T. Beddingfield, Jr.	John Glasson Mark McD. Lindsey	Charles W. Styron	3,674	13	298
116 1970	Pinehurst	580	†Edgar T. Beddingfield, Jr.	Louis deS. Shaffner	Robert P. Crouch Rose Pully	Charles W. Styron	3,711	14	289
117 1971	Pinehurst	575	Louis deS. Shaffner	Charles W. Styron	George G. Gilbert James G. Jones	E. Harvey Estes, Jr.	3,765	14	287
118 1972	Pinehurst	543	Charles W. Styron	John Glasson	Kenneth E. Cosgrove William H. Romm	E. Harvey Estes, Jr.	4,059	15	267
119 1973	Pinehurst	563	John Glasson	George G. Gilbert	Frank R. Reynolds Harry H. Summerlin	E. Harvey Estes, Jr.	4,123	15	278
120 1974	Pinehurst	623	George G. Gilbert	Frank R. Reynolds	*Michael F. Keleher †D. E. Ward, Jr.	E. Harvey Estes, Jr.	4,294	15	283
121 1975	Pinehurst	637	Frank R. Reynolds	James E. Davis	Jack Hughes M. Frank Sohmer	E. Harvey Estes, Jr.	4,598	14	303
122 1976	Pinehurst	674	James E. Davis	Jesse Caldwell	John L. McCain T. Reginald Harris	E. Harvey Estes, Jr.	4,633	14	330
123 1977	Pinehurst	728	Jesse Caldwell	E. Harvey Estes, Jr.	J. Ben Warren John C. Grier	Jack Hughes	4,824	14	338
124 1978	Pinehurst	725	E. Harvey Estes, Jr.	D. E. Ward, Jr.	Josephine E. Newell R. Bertram Williams	Jack Hughes	5,143	9	360

†) Deceased.

†) Died during term of office; succeeded by James F. Robertson, president-elect.

\*†) Resigned as First Vice-President.

\*) Became First Vice-President at resignation of Dr. Keleher.

**ROSTER OF MEMBERS OF COMMISSION FOR HEALTH SERVICES  
(Formerly State Board of Health)**

Name	Address	Appointed by	Term
James S. Raper, M.D. ....	Asheville .....	Medical Society .....	1967 to 1971
Paul F. Maness, M.D. ....	Burlington .....	Medical Society .....	1967 to 1971
Ben W. Dawsey, D.V.M. ....	Gastonia .....	Gov. Dan Moore .....	1967 to 1971
Ernest A. Randleman, Jr., PhG .....	Mount Airy .....	Gov. Dan Moore .....	1967 to 1971
Joseph S. Hiatt, Jr., M.D. ....	Southern Pines .....	Medical Society .....	1969 to 1973
Jesse H. Meredith, M.D. ....	Winston-Salem .....	Medical Society .....	1969 to 1973
Lenox D. Baker, M.D. (1) .....	Durham .....	Gov. Robert W. Scott .....	1969 to 1973
J. M. Lackey .....	Hiddenite .....	Gov. Robert W. Scott .....	1969 to 1973
Charles Barker, D.D.S. ....	New Bern .....	Gov. Robert W. Scott .....	1969 to 1973
Ralph W. Coonrad, M.D. (2) .....	Durham .....	Gov. Robert W. Scott .....	1971 to 1973
James S. Raper, M.D. ....	Asheville .....	Medical Society .....	1971 to 1975
Paul F. Maness, M.D. ....	Burlington .....	Medical Society .....	1971 to 1975
Ernest A. Randlemann, Jr., PhG .....	Mount Airy .....	Governor Robert W. Scott ...	1971 to 1975
Donald W. Lackey, D.V.M. ....	Lenoir .....	Governor Robert W. Scott ...	1971 to 1975
Jesse H. Meredith, M.D. ....	Winston-Salem .....	Medical Society .....	1973 to 1977
Maurice A. Kamp, M.D. ....	Charlotte .....	Medical Society .....	1973 to 1977
Richard T. Belton, D.D.S. ....	Gastonia .....	Gov. James E. Holshouser, Jr.	1973 to 1977
Faye B. Eagles, D.C. ....	Rocky Mount .....	Gov. James E. Holshouser, Jr.	1973 to 1977
Grady Hunter .....	Boonville .....	Gov. James E. Holshouser, Jr.	1973 to 1977
Buford W. Kidd, O.D. ....	Greensboro .....	Gov. James E. Holshouser, Jr.	1973 to 1977
Clyde W. Kiker .....	Greensboro .....	Gov. James E. Holshouser, Jr.	1973 to 1977
Paul F. Maness, M.D. ....	Burlington .....	Medical Society .....	1975 to 1979
William D. Rippy, M.D. ....	Burlington .....	Medical Society .....	1975 to 1979
Jesse H. Meredith, M.D. ....	Winston-Salem .....	Medical Society .....	1977 to 1981
G. Earl Trevathan, Jr., M.D. ....	Greenville .....	Medical Society .....	1977 to 1981

(1) Resigned when appointed Secretary, Department of Human Resources.

(2) Fill unexpired term Dr. Baker.

**ROSTER OF MEMBERS OF BOARDS OF MEDICAL EXAMINERS**

Name	Address	Term
David S. Citron, M.D. ....	Charlotte .....	1974-1980
James Jerome Pence, M.D. ....	Wilmington .....	1974-1980
Bryant L. Galusha, M.D. ....	Charlotte .....	1974-1980
Joyce H. Reynolds, M.D. ....	Kernersville .....	1976-1982
Bruce B. Blackmon, M.D. ....	Buies Creek .....	1976-1982
Louis T. Kermon .....	Raleigh .....	1978-1984
A. T. Pagter .....	Tryon .....	1978-1984
Bryant D. Paris, Jr., Executive Secretary ..	Raleigh .....	1973-



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